



# HCTC Application Addendum

Illinois Comprehensive Health Insurance Plan

[www.chip.state.il.us](http://www.chip.state.il.us)

**This Addendum Supplements the CHIP Application that you provided and is a part of that Application. Complete only if you are applying for the Health Coverage Tax Credit (HCTC).**

## Step 1: Tell us how you qualify for HCTC\*

How does the applicant qualify for HCTC?

\*HCTC Health Coverage Tax Credit: Persons who qualify for coverage based on Trade Adjustment Assistance or Pension Benefit Guaranty Corporation pensions only.

- 1. Indicate certification type:
  - Trade Adjustment Assistance (TAA)
  - Pension Benefit Guaranty Corporation (PBGC)

- 2. Provide the following information about the TAA or PBGC employer:

\_\_\_\_\_

*TAA or PBGC Company Name* *Phone # (including area code)*

\_\_\_\_\_

*Employed From Date MM/DD/YYYY* *Employed To Date MM/DD/YYYY*

## Step 2: Provide information about the HCTC certified person

*(this is the person receiving TAA or PBGC)*

- 1. \_\_\_\_\_
- First Name* *Middle Name* *Last Name*

## Step 3: To ensure HCTC qualification, is the certified person:

Tell us information regarding the certified person.

- 1. Enrolled (or enrolling) in this HCTC plan or another qualified health plan?  Yes  No
- 2. Enrolled in a health plan maintained by an employer that pays at least 50% of the cost of coverage? (The phrase "an employer" can mean your current or former employer, your spouse's current or former employer or, in the case of a dependent child, a parent's current or former employer.)  Yes  No
- 3. Entitled to Medicare Part A or enrolled in Medicare Part B?  Yes  No
- 4. Enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP)?  Yes  No
- 5. Enrolled in the Federal Employees Health Benefits Program (FEHBP)?  Yes  No
- 6. Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)?  Yes  No
- 7. Claimed as a dependent on someone else's (other than your spouse's) federal tax return this year?  Yes  No
- 8. Imprisoned under federal, state or local authority?  Yes  No
- 9. How is the applicant related to the certified person identified in Step 2, question 1 above:
  - Self  Spouse  Child  Other (please describe relationship) \_\_\_\_\_

**Step 4: If the applicant is not the certified person, is the applicant:**

Tell us information about the applicant.

- 1. Enrolled in a health plan maintained by an employer that pays at least 50% of the cost of coverage? (The phrase “an employer” can mean your current or former employer, your spouse’s current or former employer or, in the case of a dependent child, a parent’s current or former employer.) Yes No
- 2. Entitled to Medicare Part A or enrolled in Medicare Part B? Yes No
- 3. Enrolled in Medicaid or the State Children’s Health Insurance Program (SCHIP)? Yes No
- 4. Enrolled in the Federal Employees Health Benefits Program (FEHBP)? Yes No
- 5. Entitled to health coverage through the U.S. military health system (TRICARE/CHAMPUS)? Yes No
- 6. Claimed as a dependent on someone else’s (other than your spouse’s) federal tax return this year? Yes No
- 7. Imprisoned under federal, state or local authority? Yes No

**Step 5: Required Documentation and Signature**

Be sure to include all required documentation.

**We require the following documentation:**

- 1. a copy of the **Trade Adjustment Assistance (TAA)** certification or proof that you are receiving a pension through the **Pension Benefit Guarantee Corporation (PBGC)**;
- 2. a copy of the **Health Coverage Tax Credit (HCTC)** certification;
- 3. a **Certificate of Health Plan Coverage** or any other documentation you have which verifies that you have had at least 3 months of creditable coverage without a break of 63 days; and
- 4. proof from the current employer of the total (medical only) premiums for you and your family and what portion of the premium the employer pays.

I certify that the above information is correct and that this addendum is a part of my CHIP application.

\_\_\_\_\_  
*Signature of Applicant* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Custodial Parent if applicant is a minor or Legal Guardian if legally incompetent* \_\_\_\_\_  
*Date*