Internal Use only	Client Name: AMVB Retiree VEBA AMVB Health Plan Number:

Pre-65 Age 55-64 Enrollment Form

Carriers: Blue Cross Blue Shield of Michigan (BCBSM) - Medical, Prescription Drug, Dental and Blue Vision

Retiree and Spouse, each have the ability to enroll in their own plans with/without different levels of coverage as a Single person enrolling in the plan if they desire. If electing to enroll as 1 individual, each plan participant must complete separate forms and send in their checks along with their enrollment forms in separate envelopes and will each pay their individual admin fee.

Please complete enrollment form in Ink and check the applicable boxes (☐) below

Section I: Tell us about the retiree(HCTC eligible member)

			month day year
Last Name	First Name	M.I.	Date of Birth
Address	City	State	Zip code
Daytime telephone number	Social Security Number		Sex (M or F)
Retirement Date	Email Address		
☐ Salary ☐ Hourly	Name of Union, if hourly:		

Please check the appropriate Box as a Single Retiree/Spouse ☐ Retiree& Spouse ☐ Retiree and Family ☐

Section II: List Spouse and/or All Dependents That Are Enrolling – ***Relationship code S (Spouse) SS (Surviving Spouse) DP (Domestic Partner) C (Child by birth or adoption) D (Disabled child)

Name (First, MI, Last)	Relationship Code***	Sex	Date of Birth	Full-Time Student	SSN

If any family members enrolling in this plan are enrolled in Medicare please, complete the below information:

Name _____ Medicare Number _____ Effective Date: _____

Section III: Important Notes To Help You Correctly Select and Complete Your Coverage Election.

1) **You can find a complete listing of your rates on the included enrollment worksheet. Please review these rates before selecting your coverage.**
2) **When selecting your coverage please check each box that pertains to coverage you/dependents are electing. For example, if you are enrolling as a Spouse or Child only, you need to check the appropriate box.**
3) **All enrollees are eligible if the Retiree is qualified and can enroll as Standalone participants and must complete the Retiree box and the Dependents box**
4) **Family Coverage is coverage including three or more individuals.**
5) **Please review all information and sign and date where necessary.**

If you are a Retiree and/or Spouse and/or Dependent enrolling in the plan as a Single for the best pricing, each family member must complete their own form & pay individually for their plan options.

Effective Date for Coverage: /01/2019
You MUST provide an Effective Date to start coverage

Bronze Plan: Standalone Medical and Prescription Drugs including Dental and Vision

☐ Retiree ☐ Spouse ☐ Child ☐ Family

PLEASE READ THE FOLLOWING INFORMATION. THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHEILD OF MICHIGAN (BCBSM).

I am applying for coverage for myself and my family member identified on this application under my group's or association's contract with BCBSM. Coverage begins on the date determined by BCBSM. When BCBSM accepts my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM.

Authorization: I appoint my group or association to handle all matters of coverage. It may forward deductions from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM, and for other purposes necessary for BCBSM to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that BCBSM requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM for purposed of administering our coverage. Upon my request, BCBSM will tell me where the information was sent.

Retiree Signature: _____ Date: _____
(If Enrolling)

Spouse Signature: _____ Date: _____
(If Enrolling)

This enrollment form must be completed in its entirety before coverage can be issued. Any missing information will delay your enrollment in being processed. Coverage will be effective the first of the month upon receipt of the completed enrollment form.

Please return your completed enrollment form and the two month's premium payment to:
ArcelorMittal USA VEBA
4853 Galaxy Parkway Suite K
Cleveland, OH 44128
Please make your check payable to ArcelorMittal USA VEBA

Instructions for Form 13441-A
(May 2018)
Health Coverage Tax Credit (HCTC) Monthly Registration and Update

Department of the Treasury
Internal Revenue Service

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 Family Member. Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 months following the eligible individual's Medicare enrollment, death or divorce. For more information on Qualified Family Member eligibility, see Form 8885 instructions under Qualified Family Member.

☐ 6. Check here if you are updating your current monthly registration. When you 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 cost. You only need to provide the updated information.

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 registration confirmation. During this time, you must continue to pay 100% of your health insurance bills directly to your health plan and keep records of your payments. You can claim the yearly tax credit for these and any months that you met all eligibility requirements and made payments directly to a qualified health plan on your federal income tax 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 within the last 60 days that includes all of the following:**

- Your name
- Monthly premium amount
- Dates of coverage
- Health Plan name and phone number
- Health plan identification numbers
- Address for mailing your payments

If applicable, your bill must show the following:

- Dollar amount for family members who are not qualified for the HCTC
- Separate dollar amount for benefits that the HCTC does not cover *(such as separate dental or vision plans)*

Usually, your health insurance bill will have all this information on it. If it does not, you will need a letter or another document from your Health Plan that includes this information.

You should confirm with your Health Plan Provider 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 Payment Enrollment - HCTC. The IRS requires this in order to make payments on your behalf.

Your SSN _____

Form **13441-A** (May 2018)	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)*

Social Security Number (SSN)	Date of birth *(mm/dd/yyyy)*	Primary telephone number	Alternate telephone number

Mailing Address *(Street Number, City, State, ZIP)*

Part 2: Confirm Your Eligibility

Check the box that applies to you to certify that the statement is true:

☐ The HCTC Eligible Recipient is a PBGC payee and 55 years old or older.

☐ The HCTC Eligible Recipient is an eligible Trade Adjustment Assistance (TAA), Alternative TAA (ATAA), or Reemployment TAA (RTAA) recipient.

You will check the box below if you are registering as the HCTC Eligible Recipient or Qualifying Family Member.

Note: Qualified Family members of HCTC eligible individuals may receive the HCTC for up to 24 months following the eligible individual's Medicare enrollment, death or divorce. For more information on Qualified Family Member eligibility, see Form 8885 instructions under Qualified Family Member.

☐ 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 five (5) 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 each family member listed below:

- My family member is my spouse or claimed as a dependent on my federal income tax return and
- My family member meets all general requirements for the HCTC listed in Part 2 *(with the exception of the last bullet)*.

1	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person 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.	
2	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person 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)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person 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.	
4	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person 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.	
5	Family member's name *(First, Middle Initial, Last, Suffix)*	Social security number (SSN)	Date of birth *(mm/dd/yyyy)*
	Relationship to you ☐ Spouse ☐ Child ☐ Other	Is this person 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.	

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
HCTC vendor name *(name of company to be payed on your behalf)*		
HCTC vendor number *(contact your Health Plan Provider or Third Party Administrator)*		
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	

1. Total Monthly Medical Premium	
2. Total number of people *(you and any family members)* on this policy	
3. Number of family members on this policy who are not qualified for the HCTC	
4. Monthly premium amount for family members who are not qualified for the HCTC *(this amount will be removed from your total monthly medical premium and you will need to pay directly to your HPA/TPA).*	
5. **Total HCTC Total Monthly Medical Premium** *Line (1) minus line (4) and multiplied by 27.5% (.275)*	**$0.00**
6. **Other health benefits amount** *(vision, dental, non-medical benefits).* This amount will be added to your monthly HCTC payment.	
7. Monthly HCTC payment *Line 5 plus Line 6*	**$0.00**

Complete this section only if you have COBRA coverage:

☐ Check here only if the Health Plan Information in Part 4 is for 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)*

Primary telephone number

Alternate telephone number

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)

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

Privacy Act and Paperwork Reduction Act Notice

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.