

Health Plan Administrator (HPA) Return of Funds

Instructions for Returning Funds to the HCTC Program

- This form is for returning the Government's portion of the insurance premium ONLY. The participant's portion must be returned directly to the participant.
- When completing the Insured section, fill in the last four digits of insured's social security number.
- Complete the HPA Return of Funds form, and include it with your payment. This form **MUST** accompany all returned funds, in order to ensure proper handling. If your organization uses a similar form that provides ALL information requested below, submission of your internal document in lieu of this form is acceptable.
- If more than one participants is impacted by the return of the Government's Portion you must include a detail listing of all participants including Insured Names, last 4 digits of SSN, Participant's PIN, Date Coverage Ended, Reason for termination, total amount returned and reason for returned funds.
- Return funds using one of the following applicable options:

Send an HPA check (with company name and address):

Make check payable to US Treasury - HCTC.
Complete this form, attach check, and MAIL to:
Internal Revenue Service
Beckley Finance Center PO Box 9002
Beckley WV 25802-9002

Reversal of an EFT transaction:

Notify your bank that you want to reject the EFT, and request that they reverse the transaction back to the US Department of Treasury. Complete this form and FAX to:
Internal Revenue Service - HCTC
FAX #: 855-780-9044

Return an uncashed US Treasury check:

Complete this form, attach check, and MAIL to:
Internal Revenue Service
Beckley Finance Center PO Box 9002
Beckley WV 25802-9002

You can return funds for multiple individuals by using one of the following options: (1) Send a separate check and separate HPA Return of Funds Form, or, you can send an internal document for each individual, or, (2) Send one check as a bulk payment, and attach a detailed list that defines how the bulk payment should be allocated. This list must include all information that is required on the HPA Return of Funds form, for each individual for whom you are returning funds (listed below).

Use one HPA Return of Funds form per insured, completing all sections below. Please mark N/A wherever applicable.

Insured Name: _____ SSN (last 4 digits): _____

Date Coverage Ended: _____ Reason for Termination: _____

Total Amount Returned: _____

Reason for Returned Funds:

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. 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.