



Maryland HCTC Program * PO BOX 1316 * Salisbury MD 21802-1316 * 1-877-341-7697 * Fax 1-877-341-7126 * www.mdhctc.info

Check One

I receive TRA benefits, or would, but I am still drawing my Unemployment Insurance benefits		
Trade Certified Company:	Location:	
I receive ATAA benefits		
Trade Certified Company:	Location:	
I receive PBGC benefits		
Date of first pension payment (mm/dd/yyyy):		

Personal Information

Last Name:	First Name:	MI:
Address:		
City:	State:	Zip:
Social Security Number:	Date of Birth (mm/dd/yyyy):	
Home Phone Number: ()	Alternate Contact Number:()	

Health Plan Information

Health Insurance Company:		
Policy Holder's Name:	Insurance Phone Number: ()	
Monthly Premium Amount: \$	Next Premium Due Date:	
Is this COBRA coverage?	If yes, COBRA Administrator:	
COBRA Administrator Address:		
COBRA Administrator Phone: ()	Have you made your first premium payment?	

Family Member Information (List ALL family members that are on your health insurance plan)

Qualifying Family Member #1

Last Name:	First Name:	MI:
Social Security Number:	Date of Birth (mm/dd/yyyy):	
Relationship (Circle One): Spouse / Child / Other:		
I claim this person or file jointly with this person on my tax return (Circle One): Yes / No		

Qualifying Family Member #2

Last Name:	First Name:	MI:
Social Security Number:	Date of Birth (mm/dd/yyyy):	
Relationship (Circle One): Spouse / Child / Other:		
I claim this person or file jointly with this person on my tax return (Circle One): Yes / No		

Qualifying Family Member #3

Last Name:	First Name:	MI:
Social Security Number:	Date of Birth (mm/dd/yyyy):	
Relationship (Circle One): Spouse / Child / Other:		
I claim this person or file jointly with this person on my tax return (Circle One): Yes / No		



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Additional Information

(Check yes or no for each question listed below)	YES	NO
Are you, or any family member listed above, in prison?		
Are you, or any family member listed above, entitled to health coverage through TRICARE/CHAMPUS (U.S. military health benefits)?		
Are you, or any family member listed above, entitled to Medicare Part A?		
Are you, or any family member listed above, enrolled in Medicare Part B?		
Are you, or any family member listed above, enrolled in the Federal Employees Health Benefits Program (FEHBP)?		
Are you, or any family member listed above, enrolled in Medicaid		
Is any family member listed above, enrolled in the State Children’s Health Program?		
Do you, or does any member of your family listed above, have additional health insurance?		
If you answered “yes” to any of the above, please list which family member(s) _____ _____		

Under penalties of perjury, I declare that the information furnished on this form with regard to myself and any qualified family member(s), and any attachments to it, are true, correct, and complete. I understand that a knowing and willing false statement on this form can result in a disqualification from participating in the South Carolina HCTC Gap Payment Program. By signing this statement, I also agree to allow the State of Maryland HCTC Program Operator to share my eligibility status with my health plan administrator.

Signature: _____ Date: _____
Printed Name: _____

The following information should be returned to MDHCTC to determine your eligibility. If you have questions about any of the items requested, please call 1-888-341-7125. Documents should be mailed to: MDHCTC, PO Box 1316, Salisbury MD 21802-1316, or faxed to: 1-877-341-7126.

Completed Application
Age verification (photocopy of Birth Certificate <u>OR</u> Driver’s License) for each individual on the insurance, including the applicant
Photocopy of Health Insurance Bill
For applicants with COBRA coverage: Photocopy of your COBRA election letter or enrollment form that you signed and dated to elect to continue your coverage (If you do not have this form, please call the MDHCTC office for further instructions)
For PBGC Applicants Only: Verification that you receive the PBGC benefit (check stub or statement from PBGC)

Additional Information may be requested if necessary

THIS APPLICATION FOR MARYLAND HCTC IS NOT PROVIDED TO THE FEDERAL HCTC PROGRAM. IN ADDITION TO FILING THIS APPLICATION WITH MDHCTC, PLEASE INITIATE YOUR SEPARATE REGISTRATION WITH THE FEDERAL HCTC PROGRAM BY CALLING 1-866-628-4282.