



Greetings from the South Carolina Health Coverage Tax Credit (SCHCTC) Program! This program is designed to pay 80% of eligible health insurance premiums for qualified individuals. You could qualify if you meet the following criteria.

Three ways to be eligible

If you receive these benefits, you could be eligible:

1. **Trade Adjustment Assistance (TAA) benefits:** you receive unemployment insurance benefits and are eligible for Trade Readjustment Assistance (TRA), or you receive TRA benefits
2. **Alternative or Readjustment Trade Adjustment Assistance (ATAA or RTAA)**
3. **Pension Benefit Guaranty Corporation (PBGC)**

Qualifying Health Insurance

In addition, you must also be enrolled in qualified health coverage. Qualified health insurance for the SCHCTC Program includes:

- **COBRA** coverage through a former employer;
- The **State Qualifying Plan** through:
 - BlueCross BlueShield of South Carolina, 1-800-868-2500, ext 46401
 - When calling, you should ask for the “HCTC Qualifying Plan”
- **Individual (non-group) insurance** provided you were enrolled in that insurance at least 30 days prior to your last day of work.

Eligible costs

SCHCTC can pay 80% of medical premiums only. Other separate charges, such as dental or vision, are not covered by SCHCTC and will be included in your total. Additionally, COBRA participants are charged a 2% administrative fee by the COBRA provider which will not be covered by SCHCTC.

Application process

Return the completed application and required documents to the SCHCTC office. If you are eligible for SCHCTC, you will receive an “award letter” detailing your payment instructions. SCHCTC collects your portion of the premium and then forwards a full payment to the insurance company. You will be notified by mail once SCHCTC has made your payment. **You should continue to pay your insurance premiums directly to your insurance company until you receive your award letter from SCHCTC.**

Gap-filler

SCHCTC is a **temporary** “gap-filler” program that can assist with **up to three monthly premiums**. SCHCTC is designed to assist you only during the time that you are becoming enrolled in the Federal HCTC Program. You should apply with the Federal HCTC program **immediately** since it can take up to three months to become enrolled with them. Once you become enrolled with the Federal HCTC, you should notify SCHCTC. Call 1-866-628-4282 to request a Program Kit from the Federal HCTC.

South Carolina Health Coverage Tax Credit

SCHCTC
PO Box 1316
Salisbury MD 21802-1316

Phone: 1-888-341-7125
Fax: 1-877-341-7126
E-mail: info@schctc.info

To apply online or for general information: www.schctc.info

Personal Information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: (____) _____

Social Security Number: _____ Date of Birth (mm/dd/yyyy): _____

Eligibility for SCHCTC

Check one to indicate your eligibility type:

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

Health Plan Information

Health Insurance Company: _____ Policy Holder's Name: _____

Monthly Premium Amount: \$ _____ Next Premium Due Date: _____

Check one to indicate the type of health insurance that you have:

- I am enrolled in COBRA **and** I am responsible for more than 50% of the premium cost.
My COBRA Administrator is: _____
- I am enrolled in the State Qualifying Health Plan.
- I am enrolled in an individual (non-group) insurance plan **and** my effective date of coverage was at least 30 days prior to my last day of work. My last day of work was: _____. My first date of coverage was: _____.
- I am enrolled in insurance through my spouse's employer.

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

Additional Information

Check yes or no for each question listed below:

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, in prison? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, entitled to health coverage through TRICARE/CHAMPUS (U.S. military health benefits)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, entitled to Medicare Part A? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, enrolled in Medicare Part B? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, enrolled in the Federal Employees Health Benefits Program (FEHBP)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you, or any family member listed on this application, enrolled in Medicaid? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any family member listed on this application, enrolled in the State Children's Health Program? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you, or does any member of your family listed on this application, have additional health insurance? |

If you answered "yes" to any of the above, please list which family member(s) _____

Document Checklist

The following information should be returned to SCHCTC to determine your eligibility:

For all applicants:

- Completed Application
- Age verification (photocopy of Birth Certificate OR 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

For applicants with individual insurance in effect at least thirty days prior to the last day of work:

- A statement from your former employer or unemployment agency indicating your last day of work
- A statement from your insurance provider indicating that your plan is a non-group policy and stating your effective date of coverage

For PBGC applicants:

- Verification that you receive the PBGC benefit (current check stub or statement from PBGC)

Additional Information may be requested if necessary

Signature

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 agree to allow the State of South Carolina HCTC Program Operator to share my eligibility status with my health plan administrator. I also agree to allow the State of South Carolina Program Operator to share my application and supporting documents with the Federal HCTC Program Operator.

Signature: _____ Date: _____

Printed Name: _____

IN ADDITION TO FILING THIS APPLICATION WITH SCHCTC, PLEASE INITIATE YOUR SEPARATE REGISTRATION WITH THE FEDERAL HCTC PROGRAM BY CALLING 1-866-628-4282.