

Affordable Care Act/ ObamaCare
HEALTH INSURANCE QUESTIONNAIRE

First Name- Taxpayer _____ Last Name _____

First Name- Spouse _____ Last Name _____

1. Did you have health insurance for yourself & **Everyone** on your tax return for all 12 months of **2018**?

YES NO

2. What type of Insurance did you have in **2018**? Check all Boxes (a-d) that apply and indicate if you received a 1095

a Marketplace ⇒ 1095-A Received (**1095-A is REQUIRED before filing**)

b Employer Insurance ⇒ 1095-B Received 1095-C Received 1095 Not Received

c Privately Purchased Insurance ⇒ 1095-B Received 1095 Not Received

d Gov't Insurance (Medicare/ Hoosier Healthwise) ⇒ 1095-B Rec'd 1095 Not Rec'd

If you were covered all 12 months, STOP here and sign below
If not, continue on to number 3.

3. If you, or anyone on your tax return, were not covered for all 12 months of **2018**, check the months

You Were NOT Covered

Taxpayer	<input type="checkbox"/> Jan	<input type="checkbox"/> Feb	<input type="checkbox"/> Mar	<input type="checkbox"/> Apr	<input type="checkbox"/> May	<input type="checkbox"/> Jun	<input type="checkbox"/> Jul	<input type="checkbox"/> Aug	<input type="checkbox"/> Sep	<input type="checkbox"/> Oct	<input type="checkbox"/> Nov	<input type="checkbox"/> Dec
Spouse	<input type="checkbox"/> Jan	<input type="checkbox"/> Feb	<input type="checkbox"/> Mar	<input type="checkbox"/> Apr	<input type="checkbox"/> May	<input type="checkbox"/> Jun	<input type="checkbox"/> Jul	<input type="checkbox"/> Aug	<input type="checkbox"/> Sep	<input type="checkbox"/> Oct	<input type="checkbox"/> Nov	<input type="checkbox"/> Dec
Dependents	<input type="checkbox"/> Jan	<input type="checkbox"/> Feb	<input type="checkbox"/> Mar	<input type="checkbox"/> Apr	<input type="checkbox"/> May	<input type="checkbox"/> Jun	<input type="checkbox"/> Jul	<input type="checkbox"/> Aug	<input type="checkbox"/> Sep	<input type="checkbox"/> Oct	<input type="checkbox"/> Nov	<input type="checkbox"/> Dec

*If you did not have health insurance for all of **2018** you may be subject to a tax penalty unless you qualify for an exemption. Please talk to your tax professional about your specific situation.*

TAXPAYER'S STATEMENT

Under penalties of perjury, I declare that all of the information is true and correct and should be used in my tax return.

I further understand that any false statement by me and/or my spouse is considered fraud and is punishment under the law.

Taxpayer: _____ Date: _____

Spouse: _____ Date: _____

FOR OFFICE USE ONLY

Exemption	<input type="checkbox"/> A Unaffordable	Hardship	<input type="checkbox"/> Homeless
	<input type="checkbox"/> B Short Coverage Gap (2)		<input type="checkbox"/> Eviction/ Foreclosure
	<input type="checkbox"/> C Not a Citizen		<input type="checkbox"/> Utility Shut Off Notice
	<input type="checkbox"/> D Health Care Sharing Ministry		<input type="checkbox"/> Domestic Violence
	<input type="checkbox"/> E American Indian		<input type="checkbox"/> Death of close family member
	<input type="checkbox"/> F Incarcerated		<input type="checkbox"/> Natural disaster
	<input type="checkbox"/> G Limited Medicaid/ TRICARE/ VA		<input type="checkbox"/> Bankruptcy
	<input type="checkbox"/> G Aggregate Self Only Plan unaffordable		<input type="checkbox"/> Medical
	<input type="checkbox"/> H Birth or Death in Year		<input type="checkbox"/> Care for ill, disabled, or aging family member
	<input type="checkbox"/> Hardship Exemption		<input type="checkbox"/> Denied coverage in Medicaid- court order
	<input type="checkbox"/> Filed Application for Exemption		<input type="checkbox"/> Ineligible for Medicaid- state didn't expand for ACA
			<input type="checkbox"/> ECN: