Affordable Care Act/ ObamaCare

HEALTH INSURANCE QUESTIONNAIRE

Taxpayer SSN __ __ __ - __ __ - __ __ __ __ Spouse SSN __ __ __ - __ __ - __ __ __ __

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 2015?

☐ YES ☐ NO

2. What type of Insurance did you have in 2015? 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

c ☐ Privately Purchased Insurance ⇨ ☐ 1095-B Received

d ☐ Government Insurance (Medicare, Medicaid, Hoosier Healthw ⇨ ☐ 1095-B Received

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 2015, check the months *You Were NOT Covered*

Taxpayer	☐ Jan	☐ Feb	☐ Mar	☐ Apr	☐ May	☐ Jun	☐ Jul	☐ Aug	☐ Sep	☐ Oct	☐ Nov	☐ Dec
Spouse	☐ Jan	☐ Feb	☐ Mar	☐ Apr	☐ May	☐ Jun	☐ Jul	☐ Aug	☐ Sep	☐ Oct	☐ Nov	☐ Dec
Dependents	☐ Jan	☐ Feb	☐ Mar	☐ Apr	☐ May	☐ Jun	☐ Jul	☐ Aug	☐ Sep	☐ Oct	☐ Nov	☐ Dec

If you did not have health insurance for all of 2015 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
- ☐ A Unaffordable
- ☐ B Short Coverage Gap (2)
- ☐ C Not a Citizen
- ☐ D Health Care Sharing Ministry
- ☐ E American Indian
- ☐ F Incarcerated
- ☐ G Limited Medicaid/ TRICARE/ VA
- ☐ G Aggregate Self Only Plan unaffordable
- ☐ H Birth or Death in Year
- ☐ Hardship Exemption
- ☐ Filed Application for Exemption

Hardship
- ☐ Homeless
- ☐ Eviction/ Foreclosure
- ☐ Utility Shut Off Notice
- ☐ Domestic Violence
- ☐ Death of close family member
- ☐ Natural disaster
- ☐ Bankruptcy
- ☐ Medical
- ☐ Care for ill, disabled, or aging family member
- ☐ Denied coverage in Medicaid- court order
- ☐ Ineligible for Medicaid- state didn't expand for ACA
- ☐ ECN: _____