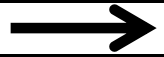


Affordable Care Act / ObamaCare
HEALTH INSURANCE QUESTIONNAIRE
Required by the IRS & Affordable Care Act

INFORMATION	
TAXPAYER	SSN or ITIN (as shown on SSA Card) _ _ - _ - _ - _ - _
FIRST NAME	LAST NAME
1. Did you have Health Insurance for <i>yourself and all your dependents</i> all 12 months of 2014? <input type="checkbox"/> YES <input type="checkbox"/> NO (if you answered NO skip to question #5)	
2. Did you receive form 1095 from your Employer, your insurance company or HHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Did you receive any Health Care Premium Credits to assist in monthly payment for Health Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO: If so how much did you receive each month \$ _____	
4. If Yes in box 1, Did you purchase your Health Insurance through Market Place / Healthcare.gov? <input type="checkbox"/> YES <input type="checkbox"/> NO Did you purchase your Health Insurance directly from an Insurance Agent? <input type="checkbox"/> YES <input type="checkbox"/> NO Was your insurance provided by your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Were you covered by Medicare or Medicaid? <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. If you check NO in box #1 Did <i>you or any of your dependents</i> have health insurance for <u>any part</u> of the year 2014? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what months <u>DIDN'T</u> you have coverage Taxpayer: <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <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"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <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"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec	
6. Do you meet any of the following criteria for exemption of Tax Penalty (check all that apply) <input type="checkbox"/> Unaffordable – lowest priced coverage available to you would cost more than 8% of your household income. <input type="checkbox"/> Short coverage gap – you went less than 3 consecutive months w/o coverage. <input type="checkbox"/> You were incarcerated (detained or in jail). <input type="checkbox"/> You are not lawfully present in the U.S. (not a citizen, nor a US National, are living Abroad, or a Resident of a Foreign Country) <input type="checkbox"/> You are a member of a recognized health care sharing ministry <input type="checkbox"/> You are a member of a recognized religious sect (religious objections to insurance, including Social Security and Medicare) <input type="checkbox"/> You are enrolled in Limited Benefit Medicaid or TRICARE or VA program. <input type="checkbox"/> Your employer has a Fiscal Year Employer Health Insurance Sponsored Plan <input type="checkbox"/> You are member of American Indian Tribe <input type="checkbox"/> You qualify for Hardship Exemption (see list on next page)	

PLEASE COMPLETE THE BACK SIDE OF THIS FORM



You qualify for Hardship Exemption (check all that apply)

- You were homeless.
- You were evicted in the last 6 months of 2014 OR you were facing eviction or foreclosure.
- You received a shut-off notice from a utility company (anytime during 2014).
- You experienced domestic violence (spouse, son, daughter, family, neighbor anyone during year 2014).
- You experienced a death of a close family member in 2014.
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- You filed for bankruptcy in the last 6 months of 2014.
- You had medical expenses you couldn't pay in 2013 or 2014 that resulted in substantial debt.
- You experienced unexpected increase in necessary expenses due to caring for ill, disabled, or aging family member.
- You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child.
- You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.
- Other _____

TAXPAYER'S STATEMENT

Under penalties of perjury, I declare that that all the above information is true and correct and should be used in completing my tax return. I further understand that any false statement by me and/or my spouse is considered fraud and is punishable under the laws of the United States Government.

Taxpayer: _____ **DATE** _____

Spouse: _____ **DATE** _____