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 *yourself and all your dependents* all 12 months of 2014? ☐ **YES** ☐ **NO** (if you answered NO skip to question #5)

2. Did you receive form 1095 from your Employer, your insurance company or HHS? ☐ YES ☐ NO

3. Did you receive any Health Care Premium Credits to assist in monthly payment for Health Insurance? ☐ YES ☐ 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? ☐ YES ☐ NO

Did you purchase your Health Insurance directly from an Insurance Agent? ☐ YES ☐ NO

Was your insurance provided by your employer? ☐ YES ☐ NO

Were you covered by Medicare or Medicaid? ☐ YES ☐ NO

5. If you check NO in box #1

Did *you or any of your dependents* have health insurance for any part of the year 2014? ☐ YES ☐ NO

If yes, what months **DIDN'T** you have coverage

Taxpayer: ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Spouse: ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Dependents: ☐Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

6. Do you meet any of the following criteria for exemption of Tax Penalty (check all that apply)
   - ☐ Unaffordable – lowest priced coverage available to you would cost more than 8% of your household income.
   - ☐ Short coverage gap – you went less than 3 consecutive months w/o coverage.
   - ☐ You were incarcerated (detained or in jail).
   - ☐ 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)
   - ☐ You are a member of a recognized health care sharing ministry
   - ☐ You are a member of a recognized religious sect (religious objections to insurance, including Social Security and Medicare)
   - ☐ You are enrolled in Limited Benefit Medicaid or TRICARE or VA program.
   - ☐ Your employer has a Fiscal Year Employer Health Insurance Sponsored Plan
   - ☐ You are member of American Indian Tribe
   - ☐ 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____

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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** ______________