

Qualified Health Insurance Coverage Questionnaire
Individual Shared Responsibility Payment

Did you have Minimum Essential Health Care Coverage for you, your spouse and all of your dependents for each month of 2017? Mark Yes or No and answer questions in that section only. Form 1095-A is REQUIRED to complete your taxes. Form 1095-B and 1095-C are not required but may be provided for anyone claimed on your tax return. When form is complete, please sign on bottom of page

_____ **YES - all year** for each person claimed on return _____ **Yes - part year** for any and all claimed on return

How was the health insurance provided?

_____ Through Employer

_____ Market place (healthcare.gov)

_____ Self- Purchased from Insurance Company (non-market place)

_____ Other Government Sponsored Provider, please circle: SSI Medicaid Medicare Tricare

For **Part year coverage** - check all months that each individual had health insurance coverage

Name	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17

_____ **NO** - No one claimed on my tax return had health insurance for any part of 2017

Was coverage offered thru your employer and you declined? ____YES ____NO. If "YES" why? _____

Why did you not have health care coverage for yourself or any dependents on tax return? _____

If you think you may be "EXEMPT" from having health care coverage, please explain:

By signing below, I verify that the information noted above is complete and accurate.

Signature: _____ Date: _____