Healthcare Coverage Questionnaire

YOU MUST PROVIDE PROOF OF HEALTH INSURANCE COVERAGE BEGINNING ON JANUARY 1, 2018.

The IRS requires that you report certain information related to your Healthcare Coverage on your 2018 Tax Return. Please read the following statement carefully. More than one may apply to your family.

1) If you had healthcare coverage with a government Marketplace (Exchange) during 2018, please provide Form 1095-A, issued by the Marketplace. In some family situations you may have more than one 1095-A.
2) If you are claiming someone on your return who was included on another taxpayer's policy, you will also need a copy of that taxpayer's 1095-A.
3) If a dependent filed a return for 2018, please provide a copy of the return.
4) If you had compliant health insurance through an employer plan, private policy, or with a government plan, please provide Form 1095-B, 1095-C or other proof of insurance document.
5) If you were issued a hardship exemption by the Marketplace (Exchange), please provide all applicable exemption certificate numbers issued for each member of your family.
6) Please provide, in the table below, you (and your family) healthcare coverage information.

Had healthcare coverage	For the entire year	For part of the year (less than 12 months) *	No healthcare coverage *
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

**If you indicated above that coverage was NOT for the entire year, please list all family members and the month(s) for which healthcare insurance was NOT covered.*

Name: _____

Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec

Name: _____

Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec

Name: _____

Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec

Name: _____

Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec

PLEASE TURN OVER AND COMPLETE

YES	NO	
☐	☐	Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?
☐	☐	Did you pay for healthcare coverage for anyone not listed above?

If you had coverage for any part of the year:

Where was the policy obtained?

Employer / Medicare / Medicaid / Marketplace (Exchange) / Other

If you did not have coverage for the entire year:

*Answer **YES** if it applies to any member of the household*

☐	☐	Was your previous insurance policy cancelled in 2018?
☐	☐	Was coverage offered by your employer or your spouse's employer?
☐	☐	Are you eligible for services through an American Indian healthcare provider?
☐	☐	Are you a member of a healthcare sharing ministry?
☐	☐	Did you live in the United States the entire year?
☐	☐	Are you enrolled in TRICARE?
☐	☐	Did you apply for CHIP coverage?
☐	☐	Do any of the following apply to you? Do NOT indicate which one.

- Became homeless
- Evicted in the past six months, or facing eviction or foreclosure
- Received a shut-off notice from a utility company
- Recently experienced domestic violence
- Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
- Filed for bankruptcy in the last six months
- Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
- Experience unexpected increases in essential expenses due to caring for an ill, disabled, or again family member

I have disclosed that the above information is correct to the best of my knowledge and I can provide and produce records if requested.

Signature: _____ Date: _____