

IMPORTANT -- NEW INFORMATION REQUIRED FOR 2014

Name:

2014	1040	Health care Coverage Questionnaire	Page 1 of 4
------	------	---	-------------

1. Did you, your spouse (if applicable) and all your dependents have health care coverage for the entire 2014 calendar year?

(Please check the appropriate box and follow the instructions)

NO Please skip this page and go to **page 2**

YES Please continue on this page to **question 2**

2. Did you purchase the health care insurance coverage through the Health Insurance Market place (Federal or State Exchanges)?

YES You must attach IRS Form 1095-A to this questionnaire and return it to our office. Please contact the health insurance market place to secure this form if you have not received it. You do not need to complete the balance of this form if you have already provided form 1095-A.

NO If you were not covered through the Exchange, but were covered through either a government-sponsored program (i.e. Medicare, Medicaid, Veteran's Healthcare programs, Tricare), an eligible employer-sponsored plan, or an individual health plan, please attach a copy of IRS form 1095-B or 1095-C you may have received **OTHERWISE** complete the attached form on page 4 providing information for all family members.

Please attach IRS form 1095-B or 1095-C, otherwise complete **Page 4**

Please go to next page

Name:

Please complete this page only if you answered **NO** to question 1.

3. Did you, your spouse (if applicable) and all dependents have "Minimum Essential Coverage" for some months during 2014 calendar year? (For information on Minimum Essential Coverage please visit our website at www.buterbaughcpa.com).

(Please check the appropriate box and follow the instructions)

YES Complete the form on page **4** and attach IRS form 1095-A, B or C (If any received).

NO Please continue on this page.

If you, your spouse or dependents did not have health insurance coverage for any months during 2014, please check the exception that you and (if applicable) your spouse and dependent(s) qualify for and **sign and date on page 3:**

Taxpayer	Spouse	Dependent(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am not a US Citizen or a US national and was either a non-resident alien or not legally in the US.

Taxpayer	Spouse	Dependent(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have attached a religious conscience exemption certificate certifying that I am a member of a religious sect that is conscientiously opposed to accepting private or public insurance.

Taxpayer	Spouse	Dependent(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have attached a certificate from the insurance exchange that I am a qualifying member of a qualified healthcare sharing ministry (in existence since Dec 31, 1999) that is exempt from the excise tax.

Taxpayer	Spouse	Dependent(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have attached a certificate from the insurance exchange that I am a member of federally recognized Indian tribe that is exempt from the excise tax.

Continued on next Page

Please go to Page 4

Name: _____

2014

1040

Health care Coverage Questionnaire (Cont'd)

Page 3 of 4

Taxpayer Spouse Dependent(s)

--	--	--

I have attached a certificate from the insurance exchange or other proof that I was confined (after disposition of all charges) in a jail, prison or other correctional facility.

Taxpayer Spouse Dependent(s)

--	--	--

I was a US citizen who lived outside of the US for at least 330 days in 2014.

Taxpayer Spouse Dependent(s)

--	--	--

I failed to have coverage for less than three consecutive months during 2014.

Taxpayer Spouse Dependent(s)

--	--	--

I have attached a hardship exemption certificate from the insurance exchange.

Taxpayer Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Please do not complete this information if coverage is indicated on Form 1095-A, 1095-B or 1095-C.

GENERAL INFORMATION

1=entire household covered for all months, 2=no months.....

If you marked "1", no need to complete the rest of the page. Just sign and date at the bottom.

COVERED INDIVIDUAL (#1)

(a) First name
(a) Last name

(b) ID number (SSN or TIN)
(c) Date of birth (m/d/y)
(d) 1=covered all 12 months ...

(e) Months of coverage:
1=January
1=February
1=March
1=April
1=May
1=June
1=July
1=August
1=September
1=October
1=November
1=December

COVERED INDIVIDUAL (#2)

(a) First name..
(a) Last name

(b) ID number (SSN or TIN)
(c) Date of birth (m/d/y)
(d) 1=covered all 12 months ...

(e) Months of coverage:
1=January
1=February
1=March
1=April
1=May
1=June
1=July
1=August
1=September
1=October
1=November
1=December

COVERED INDIVIDUAL (#3)

(a) First name
(a) Last name

(b) ID number (SSN or TIN)
(c) Date of birth (m/d/y)
(d) 1=covered all 12 months

(e) Months of coverage:
1=January
1=February
1=March
1=April
1=May
1=June
1=July
1=August
1=September
1=October
1=November
1=December

COVERED INDIVIDUAL (#4)

(a) First name
(a) Last name

(b) ID number (SSN or TIN)
(c) Date of birth (m/d/y)
(d) 1=covered all 12 months

(e) Months of coverage:
1=January
1=February
1=March
1=April
1=May
1=June
1=July
1=August
1=September
1=October
1=November
1=December

Taxpayer Signature: Date:

Spouse Signature: Date: