IMPORTANT -- INFORMATION REQUIRED FOR 2017

Name:			
2017	1040	**Health Care Coverage Questionnaire**	Page 1 of 4

1. *Please Note: If you were covered by Medicare for the entire year **check** this box* ☐ *and **just sign and date** on bottom of the page and return this page to us.*

2. Did you, your spouse (if applicable) and all your dependents have health care coverage for the **entire** 2017 calendar year? Health care coverage includes Medicare, Tricare, and Employer provided health insurance purchased through the health insurance market place.

(Please check the appropriate box and follow the instructions)

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

YES ☐ Please answer the question below.
If you receive Form 1095- B and/or 1095-C, please provide us with a copy.

3. Did you purchase health insurance through the health insurance market place? (As opposed to Medicare, Tricare or employer provided health insurance.)

NO ☐ **Please stop here and sign below**.

YES ☐ If you marked "YES" stop here and sign below. You **must** provide us with a copy of Form **1095-A** issued by the health insurance market place.

Please go to next page

Taxpayer Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Name:			
2017	1040	**Health care Coverage Questionnaire (Cont'd)**	Page 2 of 4

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

4 . Did you, your spouse (if applicable) and all dependents have "Minimum Essential Coverage" for some months during 2017 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 provide IRS form 1095-A, B and/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 2017, 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)	
			I am not a US Citizen or a US national and was either a non-resident alien or not legally in the US.
			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.
			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.
			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:			
2017	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.
			I was a US citizen who lived outside of the US for at least 330 days in 2017.
			I failed to have coverage for <u>less than three consecutive months</u> during 2017.
			I have attached a hardship exemption certificate from the insurance exchange.

Taxpayer Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Name:

2017	1040	US	Health Coverage Form	

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

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:** _____