# HEALTH CARE COVERAGE & PTC QUESTIONNAIRE

**If the item was the same for Every Month of the year X the "All Year" box. If NOT, X the Months that you had the coverage**

**If the Same Exemption applied All Year, enter Exemption Code in the "All Year" Box. If Not, Enter Code(s) in the Month boxes**

**You must provide either the Marketplace Letter with the Exemption Control Number (ECN) or Other Documentation if allowed**

| **Taxpayer Name** | **All Year** | **JAN** | **FEB** | **MAR** | **APR** | **MAY** | **JUN** | **JUL** | **AUG** | **SEP** | **OCT** | **NOV** | **DEC** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Insured through Marketplace (1095-A req) | | | | | | | | | | | | | |
| Had Health Coverage from another source | | | | | | | | | | | | | |
| Health Care Was AVAILABLE but not taken | | | | | | | | | | | | | |
| **EXEMPTION enter Code, Provide ECN Letter** | | | | | | | | | | | | | |
| **Info for Exemption Code A Worksheet** **You Must Obtain this information from your Employer(s)** | | | | | | | | | | | | | |
| Employer Offered HC that you Declined | | | | | | | | | | | | | |
| if so,Cost for SELF coverage | | | | | | | | | | | | | |
| Was Family Coverage Offered | | | | | | | | | | | | | |
| If so, Cost for FAMILY COVERAGE | | | | | | | | | | | | | |
| If so, would Spouse have been covered | | | | | | | | | | | | | |
| [ ] GOT MARRIED - DATE / / . **&** [ ] Want to use Alternate Penalty Relief Calculation | | | | | | | | | | | | | |
| [ ] Married Filing Separate RELIEF IF { } Qualifies for HOH Status, OR [ ] Victim of Domestic Abuse living apart from Spouse | | | | | | | | | | | | | |

| **Spouse Name** | **All Year** | **JAN** | **FEB** | **MAR** | **APR** | **MAY** | **JUN** | **JUL** | **AUG** | **SEP** | **OCT** | **NOV** | **DEC** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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**HOW MANY INDIVIDUALS IN TAX FAMILY**

**TAXPAYER _______ SPOUSE _______ DEPENDENTS #_________**

**TAX HOUSEHOLD ADDITIONAL MEMBERS**

**ELIGIBLE DEPENDENTS NOT CLAIMED #___________**

# HEALTH CARE COVERAGE & PTC QUESTIONNAIRE

## Dependents (D) & Eligible Dependent Tax Household Members NOT Claimed By Another (E)

| | Name D or E [ ] | All Year | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| * | Insured through Marketplace (1095-A req) | | | | | | | | | | | | | |
| | >YOU paid the Premium | Y | N | **If YES, You Must Provide the 1095-A to us** | | | | | | | | | | |
| | >Someone Else Paid The Premium | Y | N | **If YES, you must obtain the 1095-A from them to provide to us** | | | | | | | | | | |
| | >HC was **Available** from another source | Y | N | **If YES, From Where?** | | | | | | | | | | |
| * | Had Health Coverage from another source | | | | | | | | | | | | | |
| ~ | EXEMPTION enter Code, Provide ECN Letter | | | | | | | | | | | | | |
| | **FILED A TAX RETURN?** | Y | N | **If YES, Provide A Copy of the Return** | | | | | | | | | | |
| | **If Not, Provide all income documents** | | | **Do you want us to prepare a return if required?** | | | | | | | | Y | N | |

| | Name D or E [ ] | All Year | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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