**NAME:** _____ **TAX YEAR:** **2015**

## AFFORDABLE CARE ACT
## HEALTH INSURANCE QUESTIONAIRE

Unless you qualify for an exemption, you are required to have qualifying health care coverage for EVERY month of 2015.

| | Full Year | J | F | M | A | M | J | J | A | S | O | N | D |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Check to indicate full year coverage or months of coverage<br>Submit Form 1095 from Provider | | | | | | | | | | | | | |
| Coverage by parents' policy | | | | | | | | | | | | | |
| Covered by Employer Sponsored Plan | | | | | | | | | | | | | |
| Marketplace Coverage through healthcare.gov under the Affordable Care Act - Submit a copy of Forms 1095-A. | | | | | | | | | | | | | |
| Covered by Medicare/Medicaid | | | | | | | | | | | | | |
| Covered by Individual Plan NOT Self-Employed | | | | | | | | | | | | | |
| Covered by Individual Plan Self-Employed | | | | | | | | | | | | | |

If self-employed indicate premiums paid in 2015 $ _____

If self-employed were you also eligible to participate in a subsidized health plan maintained by an employer? _____ Yes _____ No

Did you qualify for an exemption from the health care coverage mandate? _____ Yes _____ No
If yes, submit a copy of the exemption certificate.

Did you **contribute to or withdraw from** a health savings account (HSA) or medical savings account (MSA)? **If yes, submit Form 5498-SA and 1099-SA** _____ Yes _____ No

If yes, are you covered by a High Deductible Health Plan? _____ Yes _____ No

Number of months covered by HDHP _____

Indicate annual deductible _____

Indicate maximum out of pocket expense _____

Note, a Health Savings Account is not QUALIFYING HEALTH CARE COVERAGE under the Affordable Care Act.