

## HEALTH INSURANCE COVERAGE

(A separate form is required for each health insurance policy held during the year.)

Policy Holder \_\_\_\_\_ Total Insurance Paid Out-of-Pocket in Year 2014 \$ \_\_\_\_\_

Health Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Date Coverage \_\_\_\_\_ to \_\_\_\_\_

Coverage Provider  Employer  Self-provided  Medicare - (STOP HERE! --- no need to fill out rest of form.)

Employer \_\_\_\_\_ - EIN # \_\_\_\_\_

Address \_\_\_\_\_

Was Health Insurance purchased online at [www.healthcare.gov](http://www.healthcare.gov) (The Marketplace)?  Yes  No *If yes, please provide the 1095-A paperwork issued by the Marketplace.*

Do you have exemption paperwork from the Affordable Care Act Health Insurance (ACA)?  Yes  No

Exemption # \_\_\_\_\_ - Please provide Exemption paperwork provided by the Marketplace.

**Other Forms to Provide/Include:**

\_\_\_\_\_ Health Insurance Medical Card

\_\_\_\_\_ 1095-B

\_\_\_\_\_ 1095-C

Check each month covered members had qualified healthcare, if not all 12 months.

Please include the following in the list below: 'HP' - Household Member Covered by Policy 'OP' - Other Member on Policy (*see below) 'NH' - Non-covered Member of Household NAME**	Please List 'HP', 'OP', 'NH'	Exempt	ALL 12 MO																	
			JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC						
*Name / SS / Birthdate	*OP																			
Address																				
*Name /SS/ Birthdate	*OP																			
Address																				

\*\* If any individual above has income, please provide a copy of their return if self-prepared. All household income must be provided for proper computation.