TODD THURSTON
TAX PREPARATION

(212) 594-4845
WWW.TAXTODD.COM

Health Insurance

Name: *Tax Year:*

If you received coverage via MEDICAID last year, place an X in the months of coverage below.

Individual	All Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Taxpayer													
Spouse													
Dependent 1													
Dependent 2													

If you received coverage via a state or federal MARKETPLACE plan, place an X in the months of coverage below. MUST provide all FORMS 1095-A.

Individual	All Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Taxpayer													
Spouse													
Dependent 1													
Dependent 2													

If you received coverage via parents, an employer or union plan, or a self-paid plan, place an X in the months of coverage below. Provide FORMS 1095-B and/or 1095-C (if received).

Individual	All Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Taxpayer													
Spouse													
Dependent 1													
Dependent 2													