Malcolm Ponder's
West Marin Tax Service

HEALTH CARE QUESTIONNAIRE - 2016

CLIENT NAME ____________________

Did you have Health care Insurance in 2016? Yes ☐ No ☐

If yes, is it: Employer Sponsored Coverage? ☐

Insurance Co: ____________________

Government Sponsored?(Medicare, Medical, VA) ☐ **(We will need Form 1095-B)**

Marketplace/Covered CA? ☐ **(We will need Form 1095-A)**

Private Pay? Monthly Premium Paid ____________________

Was your Coverage for all 12 months? Yes ☐ No ☐ **If no, see below**

If anyone moved into or out of your household during the year, please provide the names and dates.

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Did all of your dependents have Health Insurance Coverage? Yes ☐ No ☐

If no, who didn't? ____________________

If yes, were they covered under your policy or a separate policy? ☐ (My policy)

☐ (Separate policy)

If no, have you been granted an Exemption? Yes ☐ No ☐

We will need your exemption certificate number ____________________

If not, do you believe you qualify for an Exemption? Yes ☐ No ☐ Not sure ☐

Signature ____________________ Date ____________________

Name of Covered Individuals

Names:	Covered all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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3 OCEAN PARKWAY, BOLINAS, CA 94924
email: malcolmponder@hotmail.com web: www.malcolmponder.com
Tel (415) 868-1854 Fax (415) 868-1855