BENTON TAX & ACCOUNTING LLC
8900 Liberty Drive, Pleasant Valley, MO 64068
Office (816) 792-1616 - Fax (816) 792-1640

Please complete this entire form so we can provide the BEST SERVICE! Thank You!

ARE YOU A NEW CLIENT? YES Who referred you to our firm?

First, MI, Last Name		Spouse's Legal	
SS#		SS#	
Date of Birth		Date of Birth	
Occupation		Occupation	
Phone #		Phone #	

Email Address		
Address		
City, State, Zip	**COUNTY**	
Did you move IN or OUT of the city limits of KCMO durring 2017?	Yes No	Provide Dates:

Did you have health insurance covering you, spouse and all dependents every month of 2017? YES NO
Was it through work? YES NO **Was it through the Marketplace?** YES NO
If you did NOT have health insurance or it lapsed - Please complete Questionnaire on back

On December 31st were you? **SINGLE** **MARRIED**
Will you be filing separate from your spouse? YES NO
Did you live with your spouse during the year? YES NO
Date of Separation or Divorce ______________
Can you be claimed on your parents tax return or on anyone else's this year? YES NO

Who lived with you in your home? List qualified persons that you will claim.

Dependent/Child (first, initial, last name)	Social Security Number	Date of Birth	Their Relationship to You	# Months lived in your home this year	Their Annual Income

Did you provide more than half the cost of maintaining a home for a qualifying child? Yes No
Did you and your qualifying child live with anyone else for more than six months? Yes No
If you did, what was your relationship to this person? ______________

If you have a refund would you like (Please check one): ☐ Direct Deposit ☐ Check Mailed

For direct deposit ***please provide a voided check or deposit slip***

Please sign verifying the info you have provided us is accurate & complete

Date ______________ **X** ______________

Qualified Health Insurance Coverage Questionnaire

Individual Shared Responsibility Provision

Please take a moment to answer the following questions regarding your health insurance status.

Section 1

Did you have Minimum Essential Heath Care Coverage for you, your spouse and all of your dependents for each month of 2017?

a) If "**YES**" please check: _____Employer (1095-C) _____ Ins Co (NOT-Marketplace 1095-B)

___ Government (1095-B) ___Marketplace (Form 1095-A) **Go to Section 5 .**

b) If "**YES**" and you do not have any Form 1095, please provide the name of your insurance provider in section #3 and sign in section #5.

c) If "**NO**" please complete section #2 below and sign in section #5.

d) If you think you may be "**EXEMPT**" please complete section #4 below and sign in section #5.

e) Was coverage **offered** thru your employer and you declined?___Self-only __ Spouse/Family

Section 2

Check ANY month when ANY individual DID NOT HAVE health insurance coverage

Name	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Primary												
Secondary												
Dependent 1												
Dependent 2												
Dependent 3												
Dependent 4												

Section 3

Name of Insurance Provider(s): ________________________________

Section 4

Exempt? Explain your exemption: ________________________________

Section 5

Taxpayer Signature

X ______________________

Secondary Signature

X ______________________

Date: __________

PREPARER NOTES:

1. *Copy all Forms 1095 into taxpayer's file*
2. *Did you check for unaffordability or another exemption?*