TroyYoshida CPA

HEALTH INSURANCE COVERAGE VERIFICATION FORM

Taxpayer Name _____

Spouse Name _____

Tax Year _____

WHO'S COVERED (Check all that had coverage)

☐	Taxpayer	☐ Full Year	☐ Part Year	
☐	Spouse	☐ Full Year	☐ Part Year	
	Dependents (Please list)			Age
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____
☐	_____	☐ Full Year	☐ Part Year	_____

(If newborn, check full year if covered from birth)

TYPE OF COVERAGE (Check all that apply)

- ☐ Employer Provided Insurance
- ☐ Individual Policy
- ☐ Marketplace Insurance (i.e. Covered California, healthcare.gov)
  - Subsidy Received?
    - ☐ Yes ☐ No
- ☐ Medicare
- ☐ Other
- ☐ No Health Insurance Coverage

I certify that the above information is true. I also acknowledge that this information will be used to prepare my tax return.

_____ _____

Taxpayer Signature Date

_____ _____

Spouse Signature Date

Please return completed form to us via fax (714)898-6873 or email info@troycpa.com

INTERNAL USE ONLY

Exception Applies?	Yes	No	Type _____
Application Required?	Yes	No	
Certificate Received?	Yes	No	
Subsidy Calculation?	Yes	No	
Part Year Gap	_____		