Lindenbusch Accounting and Tax Service

DROP-OFFS

Date Dropped Off: _____

NAME(S): _____

Address:_____City_____State_____Zip_____

Phone #(S): _____ Best Time to Call: _____ a.m./p.m.

E-mail Address: _____

Have dependents changed? YES NO (If YES, please provide the following)

NAME: _____

D.O.B.: _____

S.S.N.: _____ (we will need a copy)

DIRECT DEPOST INFORMATION (If Changed)

BANK NAME: _____

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____ SAVINGS OR CHECKING _____

HEALTHCARE COVERAGE

Did you have minimum essential healthcare coverage* for yourself, your spouse (if filing jointly), and anyone you could or did claim as a dependent for every month of 2014? YES NO

***MINIMUM ESSENTIAL HEALTHCARE COVERAGE INCLUDES THE FOLLOWING. (Please indicate which coverage you have)**

Employer provided healthcare coverage ____

Health insurance you bought through the Health Insurance Marketplace/Exchange ____

(If enrolled through the marketplace/exchange is FORM 1095A included?
If not, please get that form to us)

Medicare, and/or most Medicaid coverage ____

Most healthcare coverage provided to veterans and active duty service members ____

Self insured ____