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HEALTH INSURANCE
MINIMUM ESSENTIAL COVERAGE (MEC) CERTIFICATION

The Affordable Care Act (ACA) federal health insurance mandate penalty was reduced to zero effective January 1, 2019 by the Tax Cuts and Jobs Act (TCJA) of 2017; however, some states continue to enforce, or have recently implemented their own health insurance mandate.

New Jersey, Massachusetts, Vermont, and the District of Columbia require that you, your spouse (if applicable), and any dependents claimed on your tax return (if applicable) have qualifying health insurance. If your home state requires it, and you do not have such coverage, you either must qualify for an exemption, or make an individual shared responsibility payment when you file your home state income tax return.

If you had health coverage in 2019, you may receive a Form 1095-A, 1095-B, or 1095-C. This form lists the individuals in your family who were enrolled in the coverage and shows their months of coverage. You do not need to attach this form to your return.

Please check the appropriate box below, sign, and return this certification to us. Your tax return(s) will not be e-filed unless we receive this signed certification along with your signed e-file authorization form(s).

CERTIFICATION STATEMENT:

☐ Check here if you and each member of your family (if applicable) ***do not*** reside in a state with a health insurance mandate.

*If you **do** reside in a state with a health insurance mandate (i.e., NJ, MA, VT, or DC):*

☐ Check here if you had "minimum essential coverage" health insurance for all of 2019, or if you qualify for an exemption. (NOTE: Most insurance plans meet minimum essential coverage. If you are not certain, you must inquire with your insurer if your plan is compliant.)

☐ Check here if you received Advance Payments of the Premium Tax Credits in 2019. If so, you will receive a Form 1095-A, and will be required to file a Premium Tax Credit Form 8962 with your tax return.

☐ Check here if you did **not** have insurance coverage for the full year, and please complete the following:

# of Months you had coverage: _____ (0 – 11)

Insurance Company name:_____

Signature: _____

Print Name: _____ Date: _____