





**Important:** Print in CAPITAL letters using black ink. File with your D-40.

OFFICIAL USE ONLY Vendor ID#0002

	resonal information				
	r daytime telephone number				
Your	r taxpayer identification number (TIN) and Date of Birth (MMDDYYYY) Spouse's/registered domestic partner's TIN and Date of Birth (MMDDYYYY)				
Your	r first name M.I. Last name				
Tour	mil. East fame				
Spor	use's/registered domestic partner's first name M.I. Last name				
Maili	ing address (number, street and suite/apartment number if applicable)				
ш					
City	State Zip Code +4				
DAF	DT   Da				
PAF	PART I Do you have qualifying health coverage?				
1	Did you and, if applicable, all members of your health care shared responsibility family have qualifying health coverage for every month in <b>2023</b> ?				
	Yes. STOP. You do not owe a health care shared responsibility payment and do not need to complete a Schedule HSR. (Enter zero				
	on Line 25 of your D-40)  No. If you answered No, complete Part II.				
	No. If you answered No, complete Fart II.				
PART II Do you have an exemption?					
2	Can someone else claim you as a dependent on their federal income tax return for 2023?				
	Yes. Proceed to Part IV. See instructions.				
_	No.				
3	Was your federal adjusted gross income below the applicable filing threshold for your filing status for 2023? See instructions  Yes. Proceed to Part IV. See instructions.				
	○ No.				
4	Was your federal adjusted gross income reported on your D-40, Line 4 for 2023 equal to or less than \$32,367.60				
	Yes. Proceed to Part IV. See instructions.				
	No.				
If you	answered Yes to any of questions 2 - 4, enter zero on Line 25 of your D-40. If not, continue by answering questions 5 - 6.				
5	Do you affirm under the penalties of perjury that you or any member of your health care shared responsibility family				
5	lacked qualifying health coverage in 2023 on the basis of a sincerely held religious belief during the entire taxable year?				
	Yes. You must complete Part III before completing Part IV.				
	○ No.				
6	Are you claiming an exemption (other than a sincerely held religious belief) for at least one month for 2023 for yourself or any member of your health care shared responsibility family?				
	Yes. You must complete Part III before completing Part IV.				
	No.				
After	· · · · · · · · · · · · · · · · · · ·				



Enter your last name					
Enter your taxpayer identification number (TIN)					
PART III What coverage exemptions are you claiming for members of your shared responsibility family and for how many months? See instructions for exemption type(s).					
Name of Indiv	idual	Taxpayer Identification Number (TIN)	Exemption Number of Exempt Months Claimed		
First name and M.I.  Zast name					
First name and M.I.  8 Last name					
9 Last name					
First name and M.I.  Last name					
First name and M.I.  Last name					
First name and M.I.  12 Last name					
PART IV Complete the applicable worksheets before completing Part IV.  Round cents to nearest dollar.					
13 Enter flat dollar amount (see Worksh	eet A-1, Line 5 or Worksheet A-2, Line 7)	13 \$	.00		
4 Enter the percentage income amount (see Worksheet B-1, Line 4 or Worksheet B-2, Line 14) 14 \$			.00		
15 Enter the larger of Line 13 or Line 1	Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the same, enter that number.)				
	Enter the District Average Bronze Plan Premium (see Worksheet C-1, Line 2 or Worksheet C-2, Line 2)				
17 Enter the smaller of Line 15 or Line	17 \$	00			