Van Blake's, Inc. Annual Intake Form — Tax Year 2018

Taxpayer

Full Legal Name: ____________________ Date of Birth: ____________

Social Security Number: ____________________ Email: ____________

Current Mailing Address: ________________________________

Home Phone Number: ____________________ Cell Ph: ____________

Employer: ____________________ Work Ph: ____________

Health Insurance Provider: ☐ Employer (1095-B) ☐ Marketplace (Form 1095-A) ☐ None Other ____________

Did you have a full year of health coverage? ☐ Yes ☐ No If no, please explain ____________

Spouse

Full Legal Name: ____________________ Date of Birth: ____________

Social Security Number: ____________________ Email: ____________

Current Mailing Address: ________________________________

Home Phone Number: ____________________ Cell Ph: ____________

Employer: ____________________ Work Ph: ____________

Health Insurance Provider: ☐ Employer (1095-B) ☐ Marketplace (Form 1095-A) ☐ None Other ____________

Did you have a full year of health coverage? ☐ Yes ☐ No If no, please explain ____________

Any dependents must be listed on the back page. (Specify "N/A" if dependents do not apply.)

Taxpayer Owned Corporation (Leave blank if you do not own a company)

Full Legal Name: ________________________________

EIN Number: ________________________________

Current Mailing Address: ________________________________

Phone Number: ____________________ Email: ____________

Banking Information

Routing Number: ________________________________

Account Number: ________________________________

CONTINUE ON BACK PAGE

Dependent:

Full Legal Name:______________________________ Date of Birth:______________

Current Mailing Address:______________________________ SS# ______________

Childcare Provider: ______________________________

Name:______________________________

Address:______________________________

Federal ID Number:______________________________

Health Insurance Provider: ☐ Employer(1095-B) ☐ Marketplace (Form 1095-A) ☐ None Other ____________

Did dependent have a full year of health coverage? ☐ Yes ☐ No If no, please explain ______________

Dependent:

Full Legal Name: ______________________________ Date of Birth: ______________

Current Mailing Address: ______________________________ SS# ______________

Childcare Provider: ______________________________

Name:______________________________

Address:______________________________

Federal ID Number:______________________________

Health Insurance Provider: ☐ Employer(1095-B) ☐ Marketplace (Form 1095-A) ☐ None Other ____________

Did you have a full year of health coverage? ☐ Yes ☐ No If no, please explain ______________

Dependent:

Full Legal Name: ______________________________ Date of Birth: ______________

Current Mailing Address: ______________________________ SS# ______________

Childcare Provider: ______________________________

Name:______________________________

Address:______________________________

Federal ID Number:______________________________

Health Insurance Provider: ☐ Employer(1095-B) ☐ Marketplace (Form 1095-A) ☐ None Other ____________

Did dependent have a full year of health coverage? ☐ Yes ☐ No If no, please explain ______________

Extension Request ☐ Personal ☐ Corporation **(Extensions are NOT automatically filed, you must request)**

TAXPAYER SIGNATURE: ______________________________ **DATE:** ______________

TAXPAYER DOES NOT WISH TO COMPLETE ANNUAL PAPERWORK. (THE OFFICE OF VAN BLAKE'S IS NOT RESPONSIBLE FOR INACCURATE INFORMATION ENTERED ON TAX RETURNS OR POOR CONTACT INFORMATION ON RECORD. BY SIGNING THE SIGNATURE LINE BELOW, THE TAXPAYER UNDERSTANDS THIS.

TAXPAYER SIGNATURE:

______________________________**DATE:**______________