

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 _____
(Penalty no longer applies for 2019)

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

Full Legal Name: _____ Date of Birth: _____

Routing Number: _____

Current Mailing Address: _____ SS# _____

Account Number: _____

Childcare Provider: _____

Dependent:

CONTINUE ON BACK PAGE

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:** _____