

VA

U.S. Department of Veterans Affairs

Veterans Health Administration

December 24, 2018



0000001042372575V523498000000 E1860-MEC-0535313 P31 T02040

0000001042372575V523498000000

DAVID WISEMAN SMALLWOOD



DAVID SMALLWOOD,

Please keep this letter and the enclosed tax form for your 2018 tax records.

The Affordable Care Act (ACA) requires the Department of Veterans Affairs (VA) to notify **enrolled Veterans** of their period of health care coverage during the previous calendar year. The law also requires VA to provide this notification to the Internal Revenue Service (IRS).

Enclosed you will find your IRS Form 1095-B, which documents your VA health care period of coverage during the year 2018. No additional steps need to be taken with this form; just follow the IRS instruction, as applicable, for completing your Health Care Individual Responsibility information on your tax return form.

What You Need to Know

Enrollment in VA health care satisfies the ACA's health care coverage requirement.

Where Can You Get More Information

If you have any questions, call us toll-free at 1-877-222-VETS (8387). You may also find additional information regarding the ACA on VA's website at www.va.gov/aca. For more information regarding the ACA's tax implications, visit www.irs.gov/Affordable-Care-Act/Individuals-and-Families.

Thank you for your service to our Nation.

Sincerely,

Dane Cornelius
Acting Director, Health Eligibility Center
VHA Member Services

702-800A
Nov 2018

0535313



Health Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID

CORRECTED

Part I Responsible Individual

1 Name of responsible individual—First name, middle name, last name DAVID WISEMAN SMALLWOOD			2 Social security number (SSN) or other TIN 0611	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 142 N 10TH ST		5 City or town GROVER BEACH	6 State or province CA	7 Country and ZIP or foreign postal code 93433-2141
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): <input type="checkbox"/> A <input checked="" type="checkbox"/> C <input type="checkbox"/> D			9 Reserved	

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)	
12 Street address (including room or suite no.)		13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name US Department of Veterans Affairs			17 Employer identification number (EIN) 74-1612229	18 Contact telephone number 877-222-8387
19 Street address (including room or suite no.) P.O. BOX 149975		20 City or town AUSTIN	21 State or province TX	22 Country and ZIP or foreign postal code 78714-8975

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
23 DAVID W SMALLWOOD	0611		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

