	ernment of the	2024 Schedule HSR SUB		
Distr	rict of Columbia	DC Health Care		
		Shared Responsibili		
Link	less Instructed otherwise- if you fill	Shared Responsibili	2 4 0 4 0 5	5 S 1 0 0 0 1
	part of this schedule, attach it to you	our D-40	SOFTWARE DEVELOPER US	SE ONLY VENDOR ID# 9999
Per	rsonal information			
	r daytime telephone number 9999	999999		
	r taxpayer identification number (TIN)		Spouse's/registered domestic partner's TIN	and Date of Birth (MMDDYYYY)
	9999999	99999999	999999999	99999999
Your	r first name	M.I. Last name		
XX	XXXXXXXXXXXXXX	x xxxxxxxxxx	XXXXXXXXXX	
Spou	use's/registered domestic partner's first	name M.I. Last name		
XX	XXXXXXXXXXXXXX	X XXXXXXXXXXX	XXXXXXXXXX	
	ling address (number, street and suite/a			
XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX		
XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX		
City			ate Zip Code + 4	
XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	X 9999999	99
		alifying health coverage?		
1		II members of your health care share	d responsibility family have qualifyin	g health coverage for every
	month in 2024?			
			ibility payment and do not need to o (Enter zero on Line 25 or	complete a Schedule HSR.
	X No. If you answered	No, complete Part II.		
		a avamption?		
	ART II Do you have ar			
2		as a dependent on their federal inco	ome tax return for 2024?	
	X Yes. Proceed to Part I	V. See instructions.		
	X No.			
2	X No.			
3	X No. Was your federal adjusted gr	oss income below the applicable filin	ng threshold for your filing status for	2024? See instructions.
3	X No. Was your federal adjusted gr X Yes. Proceed to Part	oss income below the applicable filin	ng threshold for your filing status for	2024? See instructions.
3	X No. Was your federal adjusted gr	oss income below the applicable filin	ng threshold for your filing status for	2024? See instructions.
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4	X No. Was your federal adjusted gr X Yes. Proceed to Part X No. Was your federal adjusted gr X Yes. Proceed to Part I X No.	oss income below the applicable filin IV. See instructions. oss income reported on your D-40, I IV. See instructions.		n <b>33,433.20</b> ?
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SCH	IED	ULE	HSR	PAGE	2

9 10 11 12 13 14 15 16 17



68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85

Enter your last name XXXXXXXXXXX XXXXXXXXXX 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 Individual	Taxpayer Identification Number (TIN)		Exemption Type	Number of Exempt Months Claimed
First name and M.I.				Claimeu
XXXXXXXXXXX X				
7	999999999		Х	XX
Last name				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
First name and M.I.				
XXXXXXXXXXX X 3	999999999			
	999999999		Х	XX
Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
First name and M.I.				
9	999999999		Х	XX
Last name				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
First name and M.I.				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
0	999999999		Х	XX
Last name				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
First name and M.I.           XXXXXXXXXX         X				
XXXXXXXXXXX X 1	999999999		X	XX
	9999999999			
Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
First name and M.I.				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
2	999999999		Х	XX
Last name				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				
PART IV Complete the applicable worksheets before	ore completing Part IV.			
			Round cents to nea	
3 Enter flat dollar amount (see Worksheet A-1, Line 5 or Worksheet	A-2, Line 7)	13	9999999	9.00
			9999999	0 0 0
4 Enter the percentage income amount (see Worksheet B-1, Line 4	or worksheet B-2, Line 14)	14	9999999	9.00
5 Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the	same enter that number )	15	9999999	9 0 0
		1.5		
6 Enter the District Average Bronze Plan Premium (see Worksheet C	-1. Line 2 or Worksheet C-2			
Line 2)		16	999999	9.00
7 Enter the smaller of Line 15 or Line 16 here and on D-40, Line 2	5	17	999999	9.00
Revised 09/2024				