YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC

FOR PRIVACY ACT NOTICE, SEE INSTRUCTIONS.

Form 1 Massachusetts Resident Income Tax Return 2008

FIRST NAME | M.I. | LAST NAME | 1. YOUR SOCIAL SECURITY NUMBER

SPOUSE'S FIRST NAME | M.I. | LAST NAME | 2. SPOUSE'S SOCIAL SECURITY NUMBER

ADDRESS | CITY/TOWN/POST OFFICE/FOREIGN COUNTRY | STATE | ZIP + 4

Fill in if **name/address has changed** since 2007. If **taxpayer(s) is deceased**, fill in appropriate oval(s) (see instructions): ► Primary Spouse

Fill in if veteran of U.S. armed forces who served in Operation Enduring Freedom, Iraqi Freedom or Noble Eagle (see instructions) ► You ► Spouse

State Election Campaign Fund (this contribution will not change your tax or reduce your refund) $1 You $1 Spouse, if filing jointly Total ► $

► Fill in if noncustodial parent ► Fill in if filing Schedule TDS (see instructions) Under age 18 (see instructions): ► You ► Spouse

1 Filing status: **(select one only)** Single Married filing joint return (both must sign return) Married filing separate return. (Enter spouse's Soc. Sec. number in the appropriate space above.) Head of household (see instructions)

2 Exemptions: **Whole-dollar method only. Do not use cents.**

a. Personal exemptions. If single or married filing separately, enter **$4,400**. If head of household, enter **$6,800**. If married filing jointly, enter **$8,800** 2a 00

b. Number of dependents. (**Do not** include yourself or your spouse.) Enter number ► × $1,000. . . . 2b 00
You must enclose Schedule DI.

c. Age 65 or over before 2009: You Spouse. Enter number ► × $700 . . . . . 2c 00

d. Blindness: You Spouse. Enter number ► × $2,200 . . . . . 2d 00

e. 1. Medical/Dental ► 00 From U.S. Schedule A, line 4 2. Adoption ► 00 See instructions . . . 1 + 2 = 2e 00

f. **TOTAL EXEMPTIONS.** Add lines 2a through 2e. Enter here and on line 18 . . . . . ► 2f 00

INCOME

3 Wages, salaries, tips and other employee compensation (from all Forms W-2) . . . . . ► 3 00

4 Taxable pensions and annuities (see instructions) . . . . . ► 4 00

5 a. ► 00 Massachusetts bank interest – b. ► 00 Exemption amount . . . . . a – b = 5 00

Exemption: if married filing jointly, subtract $200 from line 5a; otherwise subtract $100 and enter result (not less than "0").

▼ If showing a loss, mark an X in box at left

6 Business/profession or farm income/loss (**enclose** Massachusetts Schedule C or U.S. Schedule C-EZ or U.S. Schedule F) . . . . . ► 6 00

7 If you are reporting rental, royalty, REMIC, partnership, S corporation, trust income/loss, see instructions . . . . . ► 7 00

8 a. Unemployment compensation . . . . . ► 8a 00

b. Massachusetts state lottery winnings . . . . . ► 8b 00

9 Other income (alimony, taxable IRA/Keogh distribution, winnings, fees) from Schedule X, line 5 (**enclose** Schedule X; not less than "0") . . . . . ► 9 00

10 **TOTAL 5.3% INCOME.** Add lines 3 through 9. (Be sure to subtract any loss(es) in lines 6 or 7) . . . 10 00

SIGN HERE. Under penalties of perjury, I declare that to the best of my knowledge and belief this return and enclosures are true, correct and complete.

Your signature | Date / / | Print paid preparer's name | Preparer's SSN or PTIN ►

Spouse's signature (if filing jointly) | Date / / | Paid preparer's phone ( ) | Paid preparer's EIN ►

May DOR discuss this return with the preparer? ► Yes ► Paid preparer's signature Date Fill in if self-employed / /

I do not want my preparer to file my return electronically ►

Attach, with a single staple, state copy of Forms W-2, W-2G and 1099 (showing Massachusetts withholding).

DEDUCTIONS

11 a. Amount you paid to Social Security, Medicare, Railroad, U.S. or Mass. retirement. **Not more than $2,000.** (Medicare premiums deducted from your Soc. Sec. or retirement payments are **not** deductible.) . . . . . ► 11a .00

b. Amount your spouse paid to Social Security, Medicare, Railroad, U.S. or Mass. retirement. **Not more than $2,000.** (Medicare premiums deducted from your Soc. Sec. or retirement payments are **not** deductible.) . . . . . ► 11b .00

12 Child under age 13, or disabled dependent/spouse care expenses (from worksheet in instructions) . . . . . ► 12 .00

13 Number of dependent member(s) of household under age 12, or dependents age 65 or over (not you or your spouse) as of December 31, 2008, or disabled dependent(s) **(only if single, head of household or married filing joint return and not claiming line 12).**

Not more than two: a. ► ☐ × $3,600 = ... ► 13 .00

14 Rental deduction. **Total rental deduction cannot exceed $3,000 ($1,500 if married filing separately). See instructions.**

Total rent paid in 2008: a. ► .00 ÷ 2 = ... ► 14 .00

15 Other deductions from Schedule Y, line 16 (**enclose** Schedule Y) . . . . . ► 15 .00

16 **TOTAL DEDUCTIONS.** Add lines 11 through 15 . . . . . ► 16 .00

17 **5.3% INCOME AFTER DEDUCTIONS.** Subtract line 16 from line 10. **Not less than "0"** . . . . . 17 .00

18 Total exemption amount (from line 2, item f) . . . . . 18 .00

19 **5.3% INCOME AFTER EXEMPTIONS.** Subtract line 18 from line 17. **Not less than "0."** If line 17 is less than line 18, see instructions . . . . . 19 .00

20 **INTEREST AND DIVIDEND INCOME** from Schedule B, line 38. **Not less than "0."** (**enclose** Schedule B) . . . . . ► 20 .00

21 **TOTAL TAXABLE 5.3% INCOME.** Add lines 19 and 20 . . . . . 21 .00

22 **TAX ON 5.3% INCOME** (from tax table). If line 21 is more than $24,000, multiply by .053. **Note:** If choosing the optional 5.85% tax rate, multiply line 21 and the amount in Schedule D, line 20 by .0585. See instructions; fill in oval. ► ⬭ . . . . . 22 .00

23 **12% INCOME** from Schedule B, line 39. **Not less than "0"** (enclose Schedule B):

a. ► .00 × .12 = ... 23 .00

24 **TAX ON LONG-TERM CAPITAL GAINS** (from Schedule D, line 21). **Not less than "0." Enclose** Schedule D. If filing Sched. D-IS, Installment Sales, fill in oval and enclose Schedule D-IS ► ⬭ ► 24 .00

If excess exemptions were used in calculating lines 20, 23 or 24, fill in oval (see instructions) ► ⬭

25 Credit recapture amount (**enclose** Schedule H-2; see instructions).
⬭ BC ⬭ EOA ⬭ LIH ⬭ HR . . . . . ► 25 .00

26 If you qualify for **No Tax Status**, fill in oval and enter "0" on line 27 (see worksheet in instructions) ► ⬭

27 **TOTAL INCOME TAX.** Add lines 22 through 25 . . . . . 27 .00

CREDITS

28 Limited Income Credit (from worksheet in instructions) . . . . . ► 28 .00

29 Other credits from Schedule Z, line 14 (**enclose** Schedule Z) . . . . . ► 29 .00

30 Total credits. Add lines 28 and 29 . . . . . 30 .00

31 **INCOME TAX AFTER CREDITS.** Subtract line 30 from line 27. **Not less than "0"** . . . . . 31 .00

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32 Voluntary contributions:

a. Endangered Wildlife Conservation ▶ 32a .00

b. Organ Transplant Fund ▶ 32b .00

c. Massachusetts AIDS Fund ▶ 32c .00

d. Massachusetts United States Olympic Fund ▶ 32d .00

e. Massachusetts Military Family Relief Fund ▶ 32e .00

Total. Add lines 32a through 32e. 32 .00

33 Use tax due on out-of-state purchases (see instructions). If no use tax due enter "0" ▶ 33 .00

34 Health Care penalty (from worksheet in instructions). Be sure to **enclose** Schedule HC:

a. You ▶ .00 b. Spouse ▶ .00 a + b = 34 .00

35 **INCOME TAX AFTER CREDITS, CONTRIBUTIONS, USE TAX** and **HC PENALTY.** Add lines 31–34 35 .00

36 Massachusetts income tax withheld (**enclose** all Massachusetts Forms W-2, W-2G, 2-G, 1099-G, 1099-MISC, 1099-R and PWH-WA) ▶ 36 .00

37 2007 overpayment applied to your 2008 estimated tax (from 2007 Form 1, line 44 or Form 1-NR/PY, line 49; do not enter 2007 refund) ▶ 37 .00

38 2008 Massachusetts estimated tax payments **(do not include amount in line 37)** ▶ 38 .00

39 Payments made with extension ▶ 39 .00

40 Earned Income Credit:

a. Number of qualifying children ▶ Amount from U.S. return ▶ .00 × .15 = ▶ 40 .00

41 Senior Circuit Breaker Credit (**enclose** Schedule CB) ▶ 41 .00

42 Refundable film credit (see instructions) ▶ 42 .00

43 **TOTAL.** Add lines 36 through 42 43 .00

44 **OVERPAYMENT.** If line 35 is **smaller** than line 43, subtract line 35 from line 43. If line 35 is **larger** than line 43, go to line 47. If line 35 and line 43 are equal, enter "0" in line 46 ▶ 44 .00

45 Amount of overpayment you want **APPLIED to your 2009 ESTIMATED TAX** ▶ 45 .00

46 **THIS IS YOUR REFUND.** Subtract line 45 from line 44.
Mail to: **Massachusetts DOR, PO Box 7000, Boston, MA 02204** ▶ 46 REFUND .00

Direct Deposit of Refund. See instructions. Type of account (you must select one): ▶ ◯ Checking ◯ Savings

▶ Routing number (first two digits must be 01–12 or 21–32) ▶ Account number

47 **TAX DUE.** Subtract line 43 from line 35. Pay online at www.mass.gov/dor, or use Form PV ▶ 47 .00

Pay in full. Write Soc. Sec. number(s) on lower left corner of check and make payable to Commonwealth of Massachusetts. Mail to: **Mass. DOR, PO Box 7003, Boston, MA 02204.**

(Add to total in line 47, if applicable.) Interest ▶ .00 Penalty ▶ .00 M-2210 amt. ▶ .00 ▶ ◯ EX encl. Form M-2210

BE SURE TO SIGN RETURN ON PAGE 1 AND ENCLOSE SCHEDULE HC.

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FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2008

Most Massachusetts residents age 18 and over are required to have health insurance if it is affordable for them or be subject to a penalty. Schedule HC, Health Care Information, must be completed by all full-year residents and certain part-year residents (see instructions).

1 **a.** Date of birth ► M M D D Y Y Y Y **b.** Spouse's date of birth ► M M D D Y Y Y Y

c. Family size (see instructions) ►

2 Federal adjusted gross income. If married filing separately, see instructions. (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4) . . . . . ► 2 X , , .00

3 Did you have health insurance **at any point** during 2008? ► 3 You: Yes No Spouse: Yes No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No** or each spouse has different coverage, see instructions.

If you answer **No**, go to line 6 on page 2. If you answer **Yes**, follow the instructions below.

If you were enrolled in **Medicare, Veterans Administration Program, Tri-Care** or "Other" government health coverage **at any point** during 2008, **go to line 5** on page 2. **Note:** See below if you were enrolled in **MassHealth** or **Commonwealth Care**.

If you were enrolled in **MassHealth** and/or **Commonwealth Care** and private insurance, fill in the oval(s). Also, complete Part A and/or Part B below and then go to line 4. If you **only** had MassHealth and/or Commonwealth Care fill in the oval(s) and go to line 4.

► You: **MassHealth** and/or **Commonwealth Care**
► Spouse: **MassHealth** and/or **Commonwealth Care**

If you were enrolled in **private health insurance**, complete Part A and/or Part B below, using Form MA 1099-HC (see instructions if you did not receive Form MA 1099-HC from your carrier) and go to line 4.

Note: If you (and/or your spouse if married filing a joint return) had more than two insurance companies, complete Schedule HC-CS, Health Care Continuation Sheet (see instructions) to report the additional insurance company information, and fill in oval: ►

PART A. YOUR HEALTH INSURANCE

1. NAME OF INSURANCE COMPANY OR ADMINISTRATOR (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

PART B. SPOUSE'S HEALTH INSURANCE (you must complete even if covered under same insurance plan)

1. NAME OF INSURANCE COMPANY OR ADMINISTRATOR FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

4 Were you insured for **all** of 2008? ► 4 You: Yes No Spouse: Yes No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions. If you answer **No**, go to line 6. If you answer **Yes**, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return.

YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

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5 If you were enrolled in Medicare, Veterans Administration Program, Tri-Care or "Other" government health coverage at any point during 2008 fill in the oval below for the plan in which you were enrolled. Skip the remainder of this schedule and continue completing your tax return. See instructions for information regarding "Other" government health coverage.

5a. ▶ You: ◯ Medicare ◯ Veterans Administration Program ◯ Tri-Care ◯ Other (enter name of program below)
5b. ▶ Spouse: ◯ Medicare ◯ Veterans Administration Program ◯ Tri-Care ◯ Other (enter name of program below)

NAME OF INSURANCE CARRIER OR PROGRAM

NAME OF INSURANCE CARRIER OR PROGRAM FOR SPOUSE

UNINSURED FOR ALL OR PART OF 2008

6 Was your income in 2008 at or below 150% of the federal poverty level (see table in instructions)? ▶ **6** ◯ Yes ◯ No

If you answer **Yes**, a penalty does not apply to you in 2008. Skip the remainder of this schedule and continue completing your tax return. If you answer **No**, go to line 7.

7 Were you uninsured for **all** of 2008? ▶ **7** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions. If you answer **Yes**, go to line 9a. If you answer **No**, go to line 8.

8 Complete this section **only** if you, and/or your spouse if married filing jointly, were uninsured for part, but not all of 2008. Fill in the ovals below for the months you were covered, using Form MA 1099-HC. If you did not receive this form, fill in the ovals for the months you were covered at least **15 days or more**.

See instructions if, during 2008, you turned 18, you were a part-year resident or a taxpayer was deceased.

MONTHS COVERED BY HEALTH INSURANCE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
YOU:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
SPOUSE:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

If you had four or more consecutive months without health insurance (four or more blank ovals in a row), go to line 9a. Otherwise, a penalty does not apply to you in 2008. Skip the remainder of this schedule and continue completing your tax return.

RELIGIOUS EXEMPTION AND CERTIFICATE OF EXEMPTION

9 **a. RELIGIOUS EXEMPTION.** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs? ▶ **9a** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **Yes**, go to line 9b. If you answer **No**, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 9a, did you receive medical health care during the 2008 tax year? ▶ **9b** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **No** to line 9b, skip the remainder of this schedule and continue completing your tax return. If you answer **Yes** to line 9b, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

10 **CERTIFICATE OF EXEMPTION.** Have you obtained a Certificate of Exemption issued by the Commonwealth Health Insurance Connector Authority for the entire 2008 tax year or for the period you were uninsured in 2008? ▶ **10** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **Yes**, enter the certificate number below, skip the remainder of this schedule and continue completing your tax return. If you answer **No** to line 10, go to line 11. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR CERTIFICATE NUMBER | SPOUSE'S CERTIFICATE NUMBER

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

AFFORDABILITY AS DETERMINED BY STATE GUIDELINES

NOTE: This section will require the use of worksheets and tables found in the instructions. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2008 tax year.

11 Did your employer offer affordable health insurance as determined by completing the Schedule HC Worksheet for Line 11 in the instructions?

▶ **11** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If your employer did not offer health insurance, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

12 Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 12 in the instructions?

▶ **12** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **No**, go to line 13. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

13 Were you able to afford private health insurance as determined by completing the Schedule HC Worksheet for Line 13 in the instructions?

▶ **13** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **No**, you are not subject to a penalty. Continue completing your tax return. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

COMPLETE ONLY IF YOU ARE FILING AN APPEAL

You may have grounds to appeal if you were unable to obtain affordable insurance in 2008 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. **If you believe you have grounds for appealing the penalty, fill in the oval(s) below.** The appeal will be heard by the Commonwealth Health Insurance Connector Authority. By filling in the oval below, you are authorizing DOR to share information from your tax return, including this schedule, with the Connector Authority for purposes of deciding your appeal.

After you file your return, you will receive a follow-up letter from the Connector Authority asking you to state your grounds for appeal in writing, and submit supporting documentation. **Failure to respond to that form within the time specified will lead to dismissal of your appeal.** Once the Connector Authority receives your documentation, it will be reviewed. You may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, do **not** enter a penalty amount on your tax return. Also, do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

YOU: ◯ I wish to appeal the penalty. I authorize DOR to share my tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding my appeal.

SPOUSE: ◯ I wish to appeal the penalty. I authorize DOR to share my tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding my appeal.

Note: If you, and your spouse if married filing a joint return, do not fill in the oval(s), your appeal will not be processed, and the Health Care Penalty will be assessed.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.