Form **1095-B**

Health Coverage

► Do not attach to your tax return. Keep for your records. about Form 1095-B and its separate instructions is at www.irs.

VOID
CORRECTED

560116 OMB No. 1545-2252

2016

Internal Re	evenue Service	►inform	ation about Form 1	095-B and its separate	e instructio	ons is ai	www.ii	s.gov/to	orm109:	DD.									
Part I	Responsible	e Individual																	
1 Name of responsible individual						2	Social se	ecurity nu	mber (SS	SSN or of	her TIN is	s not avail	lable)						
4 Street address (including apartment no.)				5 City or town			6 State or province						7 Country and ZIP or foreign postal code						
8 Enter letter identifying Origin of the Policy (see instructions for codes):							9 Reserved												
Part II	Information	about Certain I	Employer-Spons	sored Coverage	(see instr	uctions	s)												
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 O	ther Coverage P	Provider (see inst	tructions)															
16 Name				ruotionsy			17 Employer identification number (EIN)					18 Contact telephone number							
19 Street address (including room or suite no.)				20 City or town			21 State or province 22 Country and						try and ZI	d ZIP or foreign postal code					
Part IV	Covered Inc	dividuals (Enter t	he information for	or each covered in	dividual)														
T GITT	(a) Name of covered	•	(b) SSN or other TI		1		(e) Months of coverage												
				,		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
23																			
24																			
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