You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential

- coverage offered to your spouse but NOT your dependent(s).

 1E. Minimum essential coverage providing minimum value offered to you and minimum essential
- coverage offered to your dependent(s) and spouse.

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 - 1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered

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11. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

Andy Na Test Sr 101A A block CAMBRIA, CA, 24566

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ANTHONY, FL, 65465

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Department of the Treasury Internal Revenue Service

Part Employee **1095-C**

OMB No. 1545-2251 2016 Applicable Large Employer Member (Employer) CORRECTED VOID ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c **Employer-Provided Health Insurance Offer and Coverage** ▶ Do not attach to your tax return. Keep for your records.

1 Name of employee	3 6				2 Social	2 Social security number (SSN)		7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	n number (EIN)
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CAMBRIA	<u> </u>	CA			24566			ANTHONY		FL		65465	2	
Part II Employee Offer of Coverage	loyee Offe	r of Cover	age					Plan Start I	Month (Ente	Plan Start Month (Enter 2-digit number):	ber):			
	All 12 Months	Jan	Feb		Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	Ħ H													
15 Employee Required Contribution (see instructions)	_	\$	↔	↔		↔	↔	\$	↔	\$	\$	↔	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F													
Part III Covered Individuals If Employer provided se	ered Indivi ployer provic	duals ded self-insu	red coverag	je, cl	heck the k	oox and ente	er the informs	ation for each	ו individual e	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. $ \overline{X} $	erage, incluc	Jing the emp	oloyee. X	
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Form **1095-C** (2016)

Cat. No. 60705M

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- 11. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

Barbie Na Test Jr 101A A block CAMBRIA, CA, 24567

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ANTHONY, FL, 65465

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1095-C Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.

OMB No. 1545-2251	2016
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▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 2F 10 Contact telephone number 12-4545465 5464646464 ↔ 8 8 2F If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. S Applicable Large Employer Member (Employer) 65465 ö 2F (e) Months of Coverage ᡐ Plan Start Month (Enter 2-digit number): 06 Sept 2F 12 State or province ᡐ 9 Street address (including room or suite no.) Aug 2F 8 July 2F 7 Name of employer () Sanju Test 12 6 Country and ZIP or foreign postal code 11 City or town ANTHONY June 456 789 2F S (c) DOB (If SSN May 2F 2 Social security number (SSN) ᡐ ***** Apr 2F S 24567 Маг 2F 8 Feb 2F CAMBRIA CA
Part II Employee Offer of Coverage S 5 State or province 2D Jan **Covered Individuals** 3 Street address (including apartment no.) 8 All 12 Months Ŧ Part | Employee Barbie Na Test Jr 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 101A A block 14 Offer of
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Charles Na Test Sr 101A A block CAMBRIA, CA, 24568

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ANTHONY, FL, 65465

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1095-C Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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	OMB No. 1545-2251	2016
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8 Employer identification number (EIN) Dec 13 Country and ZIP or foreign postal code Dec Dec 2F 10 Contact telephone number $\frac{3}{2}$ 12-4545465 5464646464 ↔ ö 8 8 2F If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. Sept S Applicable Large Employer Member (Employer) 65465 oct 2F Aug (e) Months of Coverage ᡐ July Plan Start Month (Enter 2-digit number): 06 Sept 2F June 12 State or province ᡐ May 9 Street address (including room or suite no.) Aug 2F Apr 8 Mar July 2F 7 Name of employer Feb () Sanju Test 12 6 Country and ZIP or foreign postal code 11 City or town ANTHONY June 456 789 2F Jan () (d) Covered all 12 months May 2F 2 Social security number (SSN) ᡐ (c) DOB (If SSN or other TIN is not available) ***** Apr 2F S 24568 (b) SSN or other TIN Маг 2F 8 Feb 2F Part II Employee Offer of Coverage S 5 State or province Jan 2D **Covered Individuals** (a) Name of covered individual(s) 3 Street address (including apartment no.) 8 All 12 Months Ŧ Part | Employee Charles Na Test Sr 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 101A A block 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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Cat. No. 60705M

Form 1095-C (2016)

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Diesel Na Test Jr 101A A block CAMBRIA, CA, 24569

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Department of the Treasury Internal Revenue Service 1095-C

Employer-Provided Health Insurance Offer and Coverage

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Part Employee	oloyee						Ap	plicable La	Applicable Large Employer Member (Employer)	yer Membe	er (Employ	er)	
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4 City or town		5 State or province	eo	6 Country	6 Country and ZIP or foreign postal code 11 City or town	gn postal code	11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	gn postal code
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Part II Employee Offer of Coverage	oloyee Offε	er of Covera	ıge				Plan Start Month (Enter 2-digit number): 06	Month (Ente	er 2-digit nun	iber): 06	-		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	<u></u>												
15 Employee Required Contribution (see instructions)	↔	₩.	↔	↔	₩.	↔	₩.	↔	↔	↔	↔	₩	₩
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F
Part III Covered Individuals If Employer provided se	ered Indivi	duals ded self-insu	red coverag	e. check the	box and ente	er the inform	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	individual e	nrolled in co	verade. inclu	dina the emp	lovee.	

(a) Name of covered individual(e)	(A) SSN or other TIN	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	Coveraç	ge				
		or other rin is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
17															
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ct Notice, see separate	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

Cat. No. 60705M

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee. **Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7-13, reports information about your employer

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
 1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your
- spouse or dependent(s), or you, your spouse, and dependent(s).

 1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This
- code will be entered in the All 12 Months box on line 14.

 1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

Evan Na Test Sr 101A A block CAMBRIA, CA, 24570

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that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Form 1095–C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251	2016
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Applicable Large Employer Member (Employer) ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c ▶ Do not attach to your tax return. Keep for your records.

	Joyce						בר	Applicable Large Limpleyer meringer (Limpleyer)	ii ge Eilipio	yei Mellib		(1)	
1 Name of employee	99,			2 Socia	2 Social security number (SSN)	r (SSN)	7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	number (ΕΙΝ)
Evan Na Test Sr	Sr				4009****		Sanju Test 12	2				12-4545465	55
3 Street address (including apartment no.)	including apartn	nent no.)					9 Street address (including room or suite no.)	s (including room	n or suite no.)		10 Cont	10 Contact telephone number	nber
101A A block						-	456 789					5464646464	64
4 City or town		5 State or province	nce	6 Count.	6 Country and ZIP or foreign postal code 11 City or town	gn postal code	11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	yn postal code
CAMBRIA		CA		24570	_		ANTHONY		H		65465	10	
Part Employee Offer of Coverage	Joyee Offe	er of Cover	age				Plan Start Month (Enter 2-digit number): 06	Month (Ente	r 2-digit num	iber): 06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	土												
15 Employee Required Contribution (see instructions)	↔	€	₩	↔	<i></i>	₩	₩	↔	₩	↔	↔	₩	₩
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F
Part III Cov	Covered Individuals	iduals											
If En	iployer provi	ided self-insu	ıred coveraι	ge, check the	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	er the inform	ation for each	n individual e	nrolled in cov	rerage, inclu	ding the emp	oloyee.	

(a) Nome of concept individual (c)	NIT 20 45 20 NOS (4)	(c) DOB (IT SSN	(d) Covered					(e)	Months o	(e) Months of Coverage	ge				
(a) valie of covered individual(s)		not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Ď
7															
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Form 1095-C (2016)

Cat. No. 60705M

22 For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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by the employer identified on the form. If your employer is not an Applicable Large Employer it is Employers (for example, you left employment with one Applicable Large Employer and began a employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage Form 1095-C would have information only about the health insurance coverage offered to you You are receiving this Form 1095-C because your employer is an Applicable Large Employer not required to furnish you a Form 1095-C providing information about the health coverage it new position of employment with another Applicable Large Employer). In that situation, each subject to the employer shared responsibility provision in the Affordable Care Act. This Form information will assist you in determining whether you are eligible. You may receive multiple through the Health Insurance Marketplace and wish to claim the premium tax credit, this 1095-C includes information about the health insurance coverage offered to you by your Forms 1095-C if you had multiple employers during the year that were Applicable Large offered

Instructions for Recipient

members had qualifying health coverage (referred to as "minimum essential coverage") for some and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides relationship to you (referred to here as family members), enrolled in your employer's health plan information to assist you in completing your income tax return by showing you or those family In addition, if you, or any other individual who is offered health coverage because of their or all months during the year.

Part I. Employee.

This is your social security number (SSN). For your protection, this form may show only **Line 2.** This is your social security number (SSN). For your protection, this form may show onlete last four digits of your SSN. However, the issuer is required to report your complete SSN to **Lines 1-6.** Part I, lines 1–6, reports information about you, the employee. the IRS

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for states single federal poverty line) and minimum essential coverage offered to your spouse and contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous 1A. Minimum essential coverage providing minimum value offered to you with an employee all 12 months of the calendar year.
- 1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your

- You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This spouse or dependent(s), or you, your spouse, and dependent(s)
- 1H. No offer of coverage (you were NOT offered any health coverage or you were offered code will be entered in the All 12 Months box on line 14. coverage that is NOT minimum essential coverage).
- month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one

Fasos Na Test Jr 101A A block **CAMBRIA, CA, 24571** that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10)

amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not **Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only amount reported on line 15 may not be the amount you paid for coverage if, for example, you minimum essential coverage providing minimum value that your employer offered you. The required to contribute any amount towards the premium, this line will report a "0.00" for the chose to enroll in more expensive coverage such as family coverage. Line 15 will show an

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

column (b). Column (d) will be checked if the individual was covered for at least one day in every there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in will be entered in column (e) indicating the months for which these individuals were covered. If Part I), and coverage information about each individual (including any full-time employee and month of the year. For individuals who were covered for some but not all months, information SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an hat continue Part III.

Form 1095–C
Department of the Treasury
Internal Revenue Service
Part Employee

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

	OMB No. 1545-2251	8016
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Part Employee	ployee						Ap	plicable La	arge Emplo	Applicable Large Employer Member (Employer)	er (Employ	er)	
1 Name of employee	yee			2 Sot	2 Social security number (SSN)	ber (SSN)	7 Name of employer	oyer			8 Emp	8 Employer identification number (EIN)	number (ΕΙΝ)
Fasos Na Test Jr	st Jr				9009****	90	Sanju Test 12	2				12-4545465	55
3 Street address (including apartment no.)	(including apartr	ment no.)					9 Street address (including room or suite no.)	s (including roon	n or suite no.)		10 Cont	10 Contact telephone number	nber
101A A block							456 789					5464646464	64
4 City or town		5 State or province	nce	e Cou	6 Country and ZIP or foreign postal code 11 City or town	reign postal code	11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	yn postal code
CAMBRIA		CA		24571	7.1		ANTHONY		FL		65465	10	
Part Employee Offer of Coverage	ployee Off	er of Cover	age				Plan Start Month (Enter 2-digit number): 06	Month (Ente	er 2-digit nun	1ber): 06			
	All 12 Months	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	↔	₩	₩	↔	₩	↔	\$	₩	↔	↔	₩	↔	₩
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F
Part III Cov	Covered Individuals	Covered Individuals		400000000000000000000000000000000000000		2. o dt 2. o dt	and the second s	7	;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;		4 2 2 1		

If Employer provided self-insured coverage, check the box and enter the information for each individual(s) Name of covered individual(s) Name of covered individual(s) Name of covered individual(s) Name of covered individual(s) Name of coverage, including the employee. (b) SSN or other TIN	(a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other TIN is not available)
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Form **1095-C** (2016)

Cat. No. 60705M