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 not required to furnish you a Form 1095-C providing information about the health coverage it You are receiving this Form 1095-C because your employer is an Applicable Large Employer 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

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.
- You were NOT a full-time employee for any month of the calendar year but were enrolled in 1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your 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

Ernie n Lamoureux 8067 Tanglewood Street CORONA, NY, 11368

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ANTHONY, FL, 65465

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)

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 **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

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

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251	9102
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Department of the Treasury	reasury		•	▶ Do not attach	to your tax ret	turn. Keep f	to your tax return. Keep for your records.	·å	)	COR	CORRECTED		<u> </u>
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Parti Employee	oloyee						Apl	plicable La	ırge Emplo	yer Memb	Applicable Large Employer Member (Employer)	er)	
1 Name of employee	,ee			2 Social	2 Social security number (SSN)	(NSS)	7 Name of employer	yer			<b>8</b> Emp	8 Employer identification number (EIN)	n number (EIN)
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3 Street address (including apartment no.)	including apartm	ent no.)					9 Street address (including room or suite no.)	(including room	or suite no.)		10 Conf	10 Contact telephone number	mber
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4 City or town	2	5 State or province	Se	6 Country	6 Country and ZIP or foreign postal code 11 City or town	n postal code	11 City or town		12 State or province	ovince	<b>13</b> Cour	13 Country and ZIP or foreign postal code	gn postal code
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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	2D	2D	2F	2F	2F	2F	2F	2F	2F	2F	2F
Serill Covered Individuals	ered Individ	duals											

	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	d coverage, check the	box and enter the	e informatio	n for ea	sch indi	vidual 6	urolled	in cov	erage, i	Coverage	g the	ē	employe	employee.	employee.
	(a) Name of covered individual(s)	(b) SSN or other TIN	or other TIN is	(d) Covered	- 1	-	:		(a)	5  -	5	uis oi Coverag	or coverage		-	-
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- 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
- soverage 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
- 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

coverage that is NOT minimum essential coverage).

Test Sanjay 456 789 ANTHONY, FL, 65465

Taina d Pier 209 Country Club Ave GLEN COVE, NY, 11542 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

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Form **1095-C**Department of the Treasury

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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15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	↔	\$	\$	\$		\$	₩		₩	₩.		↔	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F																
Part III Cov	<b>Covered Individuals</b>	duals															
If En	nployer provic	ded self-insur	ed coverage	e, 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	nation for e	each indi	vidual er	rolled in (	coveraç	je, incluc	ding the	employ	ee.		
meN (e)	(a) Name of covered individual(s)	idial(s)	NSS (4)	(b) SSN or other TIN	NSS (I) BOD (S)		red				(e) Mon	(e) Months of Coverage	ərage				
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Test Sanjay 456 789 ANTHONY, FL, 65465

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Department of the Treasury Internal Revenue Service 1095-C

**Employer-Provided Health Insurance Offer and Coverage** 

OMB No. 1545-225	2016
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No. 1545-2251

▶ 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.

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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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- 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
  - Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
     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-schools contained or more months of the calendar year. This
  - 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

Test Sanjay 456 789 ANTHONY, FL, 65465

Clarice e Mirabella 7568 Ohio Lane Apt 19 WILSON, NC, 27893 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 II), 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

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251	9102
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Internal Revenue Service	•	<b>▶</b> Infor	mation abc	out Form	1095-C	▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	arate ins	tructions	is at ww	vw.irs.ga	ov/form	1095c								
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F																			
Part III Covere	Covered Individuals If Employer provided se	<b>Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	red covera	ige, che	ck the b	ox and ente	er the in	ıformatio	in for ea	ch indiv	/idual e	nrolled	in cove	rage, in	cluding	the en	рюуее			
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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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#### Instructions for Recipient

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. 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.

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.
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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.
- 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

Lisenew ne Lemastersnew Sr 8767 Rose Avenue BRANFORD, CT, 64055 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

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1095-C Department of the Treasury Internal Revenue Service

**Employer-Provided Health Insurance Offer and Coverage** 

▶ 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.

OMB No. 1545-225	2016
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No. 1545-2251

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 2F 10 Contact telephone number 11-5464646 5464646464 ₩ 8 8 2F S Applicable Large Employer Member (Employer) 65465 ö 2F 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 S Test Sanjay 6 Country and ZIP or foreign postal code 11 City or town ANTHONY June 456 789 2F S May 2F 2 Social security number (SSN) S \*\*\*\*\*4514 Apr 2F S 64055 Маг 2F 8 Feb 2D Part II Employee Offer of Coverage S 5 State or province Jan 2D **Covered Individuals** 3 Street address (including apartment no.) -isenew ne Lemastersnew Sr 8 All 12 Months Ŧ Part | Employee 8767 Rose Avenue 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) BRANFORD 14 Offer of
Coverage (enter
required code)
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Required
Contribution (see
instructions) 4 City or town Part III

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Form 1095-C (2016)

Cat. No. 60705M

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