Instructions for Recipient

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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).
1I. 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 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 amount.
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.

Natalie Bengtson
1 Main Street Apt A
DELLWOOD, MN, 55110

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Natalie Bengtson	*****0001

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
DELLWOOD	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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).
1I. 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 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).
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Amy Bramley
1 Main Street Apt A
LINWOOD, MN, 55092

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Amy Bramley	*****0002

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
LINWOOD	MN	55092

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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).
1I. 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

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Sara Coons
1 Main Street Apt A
COON RAPIDS, MN, 55448

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 amount.
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600117

Form **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.**

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☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Sara Coons	*****0005

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
COON RAPIDS	MN	55448

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Anthony Deutsch
1 Main Street Apt A
LINDSTROM, MN, 55045

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Anthony Deutsch	*****0006

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
LINDSTROM	MN	55045

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Angel Dilley
1 Main Street Apt A
LINO LAKES, MN, 55014

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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Internal Revenue Service

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☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Angel Dilley	*****0007

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
LINO LAKES	MN	55014

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7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

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ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2D	2D	2H	2H	2H	2H	2H	2H

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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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.

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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).
1I. 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 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).
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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.

Robert Disrud
1 Main Street Apt A
NORTH BRANCH, MN, 55056

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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Department of the Treasury
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OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Robert Disrud	*****0008
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
NORTH BRANCH	MN	55056

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

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Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

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Daniel Eggert
1 Main Street Apt A
COON RAPIDS, MN, 55448

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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

Part I Employee

1 Name of employee	2 Social security number (SSN)
Daniel Eggert	*****0009

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
COON RAPIDS	MN	55448

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2C

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

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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).
1I. 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 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 amount.
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.

Scott Erickson
1 Main Street Apt A
ROBBINSDALE, MN, 55422

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Scott Erickson	*****0010

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
ROBBINSDALE	MN	55422

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Jesse Forliti
1 Main Street Apt A
OAK GROVE, MN, 55005

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jesse Forliti	*****0011
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
OAK GROVE	MN	55005

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Richard Gilbert
1 Main Street Apt A
EAST BETHEL, MN, 55005

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Richard Gilbert	*****0012

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
EAST BETHEL	MN	55005

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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Part I. Employee.

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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 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).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. 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 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).
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Part III. Covered Individuals, Lines 17-22

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Donovan Hall
1 Main Street Apt A
SHAFER, MN, 55074

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Donovan Hall	*****0013
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
SHAFER	MN	55074

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Nancy Iacarella
1 Main Street Apt A
NOWTHEN, MN, 55303

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Nancy Iacarella	*****0014
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
NOWTHEN	MN	55303

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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.

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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).
1I. 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 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 amount.
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.

Brandon Jenc
1 Main Street Apt A
PRIOR LAKE, MN, 55372

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Brandon Jenc	*****0015
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
PRIOR LAKE	MN	55372

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2C	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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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).
1I. 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 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).
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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.

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Phillip Johnson
1 Main Street Apt A
BLAINE, MN, 55434

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Phillip Johnson	*****0016

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
BLAINE	MN	55434

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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).
1I. 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 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 amount.
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.

Richard Kiesling
1 Main Street Apt A
WHITE BEAR LAKE, MN, 55110

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Richard Kiesling	*****0017
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
WHITE BEAR LAKE	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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).
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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.

Joseph Kuskey
1 Main Street Apt A
WYOMING, MN, 55092

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Joseph Kuskey	*****0019
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
WYOMING	MN	55092

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2D	2D	2H	2H	2H	2H

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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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.

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Daniel Nelson
1 Main Street Apt A
NORTH BRANCH, MN, 55056

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Daniel Nelson	*****0020
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
NORTH BRANCH	MN	55056

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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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.

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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.
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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.
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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.

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Gerald Paul
1 Main Street Apt A
BURNSVILLE, MN, 55337

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Gerald Paul	*****0021
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
BURNSVILLE	MN	55337

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2D	2D	2H	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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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.

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Part I. Applicable Large Employer Member (Employer)

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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 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).
1I. 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 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).
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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.

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Michael Poppler
1 Main Street Apt A
SO ST PAUL, MN, 55075

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Michael Poppler	*****0022

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
SO ST PAUL	MN	55075

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2H	2H	2H	2H	2H	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

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Jason Reichert
1 Main Street Apt A
FRIDLEY, MN, 55432

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jason Reichert	*****0023
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
FRIDLEY	MN	55432

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2C	2C	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Randahl Rust
1 Main Street Apt A
HUGO, MN, 55038

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Randahl Rust	*****0024

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
HUGO	MN	55038

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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1I. 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 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 amount.
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.

Derrek Skeie
1 Main Street Apt A
WHITE BEAR LAKE, MN, 55110

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Derrek Skeie	*****0025
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
WHITE BEAR LAKE	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Robert Skeie
1 Main Street Apt A
WHITE BEAR LAKE, MN, 55110

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Robert Skeie	*****0027
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
WHITE BEAR LAKE	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.
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).
1I. 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 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 amount.
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.

Jamie Swan
1 Main Street Apt A
EAGAN, MN, 55121

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jamie Swan	*****0028

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
EAGAN	MN	55121

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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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.

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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.

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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 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).
1I. 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

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Sokhamony Ung
1 Main Street Apt A
MINNEAPOLIS, MN, 55406

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 amount.
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.

600117

Form **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.**

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Sokhamony Ung	*****0029

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
MINNEAPOLIS	MN	55406

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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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.

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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).
1I. 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 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 amount.
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.

Carolyn Wesley
1 Main Street Apt A
HAM LAKE, MN, 55304

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Carolyn Wesley	*****0030
3 Street address (including apartment no.)	
1 Main Street Apt A	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
HAM LAKE	MN	55304

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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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.

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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).
1I. 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 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).
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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.

Anna Wicks
1 Main Street Apt A
WHITE BEAR TWSP, MN, 55110

Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Anna Wicks	*****0031
3 Street address (including apartment no.)	
1 Main Street Apt A	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
WHITE BEAR TWSP	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616
9 Street address (including room or suite no.)	**10** Contact telephone number
1 Testing Street Suite T	1561656066
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Twin City Mechanical
1 Testing Street Suite T
ABBEVILLE, AL, 12345

Melinda Wisgerhof
1 Main Street Apt A
WHITE BEAR TWSP, MN, 55110

600117

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Melinda Wisgerhof	*****0032

3 Street address (including apartment no.)
1 Main Street Apt A

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
WHITE BEAR TWSP	MN	55110

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Twin City Mechanical	13-1321616

9 Street address (including room or suite no.)	10 Contact telephone number
1 Testing Street Suite T	1561656066

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ABBEVILLE	AL	12345

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 10

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐