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Natalie Bengtson 1 Main Street Apt A

DELLWOOD, MN, 55110

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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Form 1095-C Department of the Treasury Internal Revenue Service

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c ▶ Do not attach to your tax return. Keep for your records.

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Department of the Treasury	asury	Ī	•	Do not atta	▶ Do not attach to your tax return. Keep for your records.	c return	. Keep for y	our reco	rds.		)		8	CORRECTED		9,		<u>u</u>	
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emeN (e)	(a) Name of covered individual(s)	id ial(s)	Nos (d)	IN SSN or other TIN	(c) DOB (If	SSN	(d) Covered					(e) ∨	(e) Months of Coverage	overage					
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Form 1095-C (2016)

Cat. No. 60705M

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  - 12. Willing the Section Coverage providing finition value offered to you and finition essential coverage offered to your dependent(s) and spouse.
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LINWOOD, MN, 55092

Amy Bramley
1 Main Street Apt A

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1095-C

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

	OMB No. 1545-2251	2016
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3 Street address (including apartment no.)	apartment no.)			_			9 Stre	9 Street address (including room or suite no.)	g (including	room or s	uite no.)			10 Cor	10 Contact telephone number	one numb	er
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2H	T																
Part III Covered Individuals	ndividuals															     [	
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Form **1095-C** (2016)

Cat. No. 60705M

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

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

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ABBEVIĽLE, AL, 12345

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Sara Coons					4000****	10	Twin City Mechanical	echanical				13-1321616	16
3 Street address (including apartment no.)	ncluding apartr	ment no.)					9 Street address (including room or suite no.)	s (including room	or suite no.)		10 Con	10 Contact telephone number	nber
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For Privacy Act and Paperwork Reduction Act Notice, see separate insti	ct Notice, see separate	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

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LINDSTROM, MN, 55045

Anthony Deutsch 1 Main Street Apt A

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### Part III. Covered Individuals, Lines 17-22

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1 Name of employee			2 Social	Social security number (SSN)		7 Name of employer	mployer						<b>8</b> Emp	oloyer ide	ntificatio	8 Employer identification number (EIN)	r (EIN)
Anthony Deutsch				9000****	^	Twin City Mechanical	Mechai	nical						13-	3-1321616	16	
3 Street address (including apartment no.)	ant no.)				6	9 Street address (including room or suite no.)	ress (inclu	ding room	or suite n	0.)			<b>10</b> Con	10 Contact telephone number	phone nu	mber	
1 Main Street Apt A					<u>`</u>	Testing Street Suite T	Street !	Suite T						156	1561656066	99(	
	5 State or province	Ф	6 Country	6 Country and ZIP or foreign postal code	_	11 City or town	L,		12 State	State or province	ce		13 Cou	ntry and Z	IP or fore	13 Country and ZIP or foreign postal code	code
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Part II Employee Offer of Coverage	r of Coveraç	зе			Ā	Plan Start Month (Enter 2-digit number):	t Mon	: <b>h</b> (Enter	2-digit	numbe	er): 10						
All 12 Months	Jan	Feb	Mar	Apr	May	June		July	Aug	_	Sept		Oct	z	Nov	Dec	U
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)																	
Part III Covered Individuals	luals	-	1 1 1 1	-			-	-	=		-	=		_			
וו בחוסוטיפר provided sell-insured coverage, check the box and enter the miormation for each movidudal enfolsed in coverage, including the employee.	aed sell-linsure	ed coverage,	, cneck the	(c) DOB (If SSN			acri indiv	/Idual er	Lolled		overage, including	overage overage	lue eu	oloyee.			
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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Cat. No. 60705M

Form **1095-C** (2016)

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

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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

	OMB No. 1545-2251	2016
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1 Name of employee	99,			2 Social	2 Social security number (SSN)		7 Name of employer	mployer						8 Employ	8 Employer identification number (EIN)	ation nun	ber (EIN)
Angel Dilley					<b>2000</b> *****		Twin City Mechanical	Mechai	nical						13-1321616	1616	
3 Street address (including apartment no.)	including apartmer	nt no.)					9 Street address (including room or suite no.)	ress (inclu	iding room	or suite n	(; ()			10 Contact telephone number	t telephon	e number	
1 Main Street Apt A	Apt A					<u>,</u>	1 Testing Street Suite	Street !	Suite T						1561656066	99099	
4 City or town	5	5 State or province	)e	6 Countr	6 Country and ZIP or foreign postal code	_	11 City or town	Ę		12 State	State or province	e e		13 Country and ZIP or foreign postal code	and ZIP or	foreign pos	tal code
<b>LINO LAKES</b>	MM	z		55014		<del></del>	ABBEVILLE	Щ		AL			<u> </u>	12345			
Part    Emp	<b>Employee Offer of Coverage</b>	of Covera	ge				Plan Start Month (Enter 2-digit number):	t Mont	t <b>h</b> (Ente	r 2-digit	numbe	7): 10					
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July	Aug		Sept	0	Oct	Nov		Dec
14 Offer of Coverage (enter required code)		Ŧ	Ħ	#	1H	H H	H H		<b>4</b> 1	14		4	—	1A	₹		4 
15 Employee Required Contribution (see instructions)	€	€	↔	₩	€9	↔	₩	₩.		<del>\$</del>	₩		↔	₩		↔	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2D	2D		2H	2H		2H	2	2H	2H		2H
Part III Cov	Covered Individuals If Employer provided se	<b>uals</b> ed self-insur	ed coverage	e, check the	<b>Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	r the informs	ation for ea	ach indiv	vidual e	rolled ir	covera	age, incli	uding th	e emplo	yee.		
(a) Name	(a) Name of covered individual(s)	dual(s)	NSS (q)	(b) SSN or other TIN	(c) DOB (If SSN		pe				(e) W	(e) Months of Coverage	verage	1			
		(2)	No (a)		not available)	all 12 months	ths Jan	Feb	Mar	Apr N	Мау Ј	June July	ly Aug	g Sept	t Oct	Nov	Dec
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Form **1095-C** (2016)

Cat. No. 60705M

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- Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
   Minimum essential coverage NOT providing minimum value offered to you, or you and your
  - spouse or dependent(s), or you, your spouse, and dependent(s).

    1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This
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Robert Disrud 1 Main Street Apt A NORTH BRANCH, MN, 55056

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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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	9102
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Part   Employee	oloyee								_	Applicable Large Employer Member (Employer)	Large	<b>Employ</b>	er Membe	r (Emplo)ء	yer)	
1 Name of employee	,ee				7	Social sec	2 Social security number (SSN)	r (SSN)	7 Name of employer	mployer				8 Er	nployer identific	8 Employer identification number (EIN)
Robert Disrud	70						8000****	~	Twin City	Twin City Mechanical					13-1321616	1616
3 Street address (including apartment no.)	including aparti	ment no.)							9 Street add	9 Street address (including room or suite no.)	oom or sui	te no.)		<b>10</b> O	10 Contact telephone number	e number
1 Main Street Apt A	Apt A								1 Testing	1 Testing Street Suite 1	Lέ				1561656066	99099
4 City or town		5 State or province	rovince		9	Country ar	nd ZIP or forei	gn postal code	6 Country and ZIP or foreign postal code 11 City or town	vn	<b>12</b> St	12 State or province	ince	<b>13</b> ℃	ountry and ZIP or	13 Country and ZIP or foreign postal code
NORTH BRANCH		NM			55	55056			ABBEVILLE	LE LE	AL			12345	45	
Part II Employee Offer of Coverage	oloyee Off	er of Cov	erage						Plan Sta	Plan Start Month (Enter 2-digit number): 10	nter 2-di	git numb	er): 10	+		
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14 Offer of Coverage (enter required code)	1A															
15 Employee Required Contribution (see instructions)	↔	↔	↔		₩.	<del>(9)</del>		₩	↔	₩	↔	<del> </del>	\$	₩	₩	<i></i>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C															
Part III Covered Individuals	ered Indiv	riduals	1				7000	1,04c; 0,04 %	20,100	Covered Individuals		<u> </u>	0000	4 5017		

(c) DOB (if SSN   (d) Covered (e) Months of Coverage		NSS JI) BOD (c)	(d) Covered			5		(e)	(e) Months of Coverage	f Covera	a e		] ;		
(a) Name of covered individual(s)	(b) SSN or other IIN	or other IIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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For Privacy Act and Paperwork Reduction Act Notice, see separate insti	ct Notice, see separate	instructions.				Cat.	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

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**1095-C** Department of the Treasury Internal Revenue Service

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form ▶ Do not attach to your tax return. Keep for your records.

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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec 2C 7 10 Contact telephone number 13-1321616 1561656066 S 8 8 1 2D S Applicable Large Employer Member (Employer) 12345 ö 1 2D ᡐ Plan Start Month (Enter 2-digit number): 10 Sept 2D 1 12 State or province ↔ 9 Street address (including room or suite no.) Aug 2A 1 ₩ 1 Testing Street Suite T Twin City Mechanical July 1 2A 7 Name of employer <del>()</del> ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June 1 2A S 2A May 1 2 Social security number (SSN) ᡐ 6000\*\*\*\* Apr 1 2A S 55448 Mar 1 2A 8 Feb 1 **2**A Part II Employee Offer of Coverage S 5 State or province Jan 1 2A Part III Covered Individuals Street address (including apartment no.) Z 8 All 12 Months Part | Employee 1 Main Street Apt A COON RAPIDS 1 Name of employee Daniel Eggert 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

the box and enter the information for each individual enrolled in coverage, including the employee.		wered (e) Months of Coverage	months los Est Max Ass No. 1.11. And Seet No.
e inforr		( <b>d</b> ) Cov	al 12 m
e box and enter th		(c) DOB (If SSN	
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If Employer provided self-insured coverage of	المالية	(a) Name of covered individual(e)	a) Ivalille of covered interviously

(a) Name of covered individual(s)	(a) SSN or other IIN	or other TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ct Notice, see separate i	nstructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

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

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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

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

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

### Part III. Covered Individuals, Lines 17-22

Department of the Treasury Internal Revenue Service **1095-C** 

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

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

Pari	loyee							Ap	plicable La	Applicable Large Employer Member (Employer)	yer Membe	∍r (⊑mploye	er)	
1 Name of employee	ee			2 So	2 Social security number (SSN)	number (St	SN)	7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	n number (EIN)
Scott Erickson	u				***	*****0010	-	Twin City Mechanical	echanical				13-1321616	16
3 Street address (including apartment no.)	ncluding apartme	ent no.)						9 Street address (including room or suite no.)	s (including roor	n or suite no.)		<b>10</b> Cont	10 Contact telephone number	mber
1 Main Street Apt A	Apt A							1 Testing Street Suite T	reet Suite T				1561656066	991
4 City or town	2	5 State or province	eo eo	<b>9</b> Cor	6 Country and ZIP or foreign postal code	or foreign p	ostal code	11 City or town		12 State or province	ovince	<b>13</b> Coun	13 Country and ZIP or foreign postal code	gn postal code
ROBBINSDALE		NΜ		55422	22			ABBEVILLE		AL		12345	10	
Part II Employee Offer of Coverage	oloyee Offer	r of Covera	ge	•				Plan Start Month (Enter 2-digit number): 10	<b>Month</b> (Ente	er 2-digit num	lber): 10			
	All 12 Months	Jan	Feb	Mar	٩	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A													
15 Employee Required Contribution (see instructions)	8	<del>\$</del>	₩	↔	↔	₩		↔	↔	₩	↔	\$	₩	<del>\$</del>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H													
Part III Covered Individuals	ered Individ	duals		+ 100 do	od	- to to	- di oq	Covered Individuals  # Employer provided self-inclined coverage check the box and enter the information for each individual enrolled in coverage inclinding the employee	ַ <u></u>					

(c) DOB (If SSN   (d) Covered		(c) DOB (If SSN	(d) Covered	5	5	5	5	(e)	(e) Months of Coverage	Coverag	2	25	]		
(a) Name of covered individual(s)	(b) SSN or other IIIN	or other IIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															

Form **1095-C** (2016)

Cat. No. 60705M

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. 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).
- 11. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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

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

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

### Part III. Covered Individuals, Lines 17-22

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

OMB No. 1545-2251	2016
<u>:</u>	CORRECTED

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Part   Employee	oyee								App	Applicable Large Employer Member (Employer)	Large	Emplo	/er Me	mber (	Emplo	yer)			
1 Name of employee	0				2 Social	2 Social security number (SSN)	(NSS)	7 Nam	7 Name of employer	yer					<b>8</b> □	8 Employer identification number (EIN)	dentification	qunu uc	er (EIN)
Jesse Forliti						*****0011		Twin (	Twin City Mechanical	chanica						13	3-1321616	516	
3 Street address (including apartment no.)	oluding apartm	ent no.)						9 Stree	9 Street address (including room or suite no.)	(including r	oom or su	ite no.)			10 C	10 Contact telephone number	ephone n	umber	
1 Main Street Apt A								$\overline{}$	<b>Testing Street Suite</b>	eet Suite	_ ∈					15	1561656066	990	
4 City or town	4)	5 State or province	ce		6 Country	6 Country and ZIP or foreign postal code	yn postal code	11 City or town	or town		<b>12</b> S	12 State or province	vince		13 Co	13 Country and ZIP or foreign postal code	ZIP or fore	eign posta	l code
OAK GROVE		NΜ			52005			ABBE	ABBEVILLE		٩٢				12345	45			
Part II Emplo	oyee Offe	<b>Employee Offer of Coverage</b>	age .					Plan	Plan Start Month (Enter 2-digit number):	onth (E	nter 2-d	igit num	ber): 10	0					
	All 12 Months	Jan	Feb		Mar	Apr	May	7	June	July		Aug	Sept		Oct	_	Nov	ă	Dec
14 Offer of Coverage (enter required code)	1A																		
15 Employee Required Contribution (see instructions)	40	₩	↔	₩		₩	↔	₩		€	↔		<del>\$</del>	₩		₩		↔	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C																		
Part III Cove	Covered Individuals	duals	-			-	1					.!		-		-			
IT EMP	loyer provi	It Employer provided self-insured coverage, cneck the box and enter the information for each individual enrolled in coverage, including the employee.	red cover	age, cn	leck the t	oox and ente	er the Intor	mation T	or each	naiviaus	il enrolle	o III co	erage, II	Sunding	tne en	npioyee			
(a) Name of	(a) Name of covered individual(s)	vidual(s)	ISS ( <b>q</b> )	(b) SSN or other TIN		(c) DOB (If SSN or other TIN is			ŀ	ŀ	ŀ	<b>9</b>	(e) Months of Coverage	Coverag					
			;			not available	all 12 months		Jan Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
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For Privacy Act and Paperwork Reduction Act Notice. see separate instructions.	d Paperwor	'k Reduction A	Act Notice.	See Se	parate ins	structions.				- Za	Cat No 60705M	15M					Form <b>1</b>	Form <b>1095-C</b> (2016)	(2016)

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.
  - 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).
- Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
   Minimum essential coverage NOT providing minimum value offered to you, or you and your
  - spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

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

Richard Gilbert 1 Main Street Apt A EAST BETHEL, MN, 55005 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

### Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury

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

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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 1 2A B No. 1545-2251 **9**100 10 Contact telephone number 13-1321616 1561656066 S 8 8 1 2A S Applicable Large Employer Member (Employer) 12345 oct 1 2A ᡐ Plan Start Month (Enter 2-digit number): 10 Sept 1 2A 12 State or province ᡐ 9 Street address (including room or suite no.) Aug 2A 1 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c ₩ 1 Testing Street Suite Twin City Mechanical July 1 2A 7 Name of employer <del>()</del> ▶ Do not attach to your tax return. Keep for your records. ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June 1 2A S May 1 2A 2 Social security number (SSN) ᡐ \*\*\*\*\*0012 Apr 1 2A S 52005 Mar 1 2A 8 Feb 1 2A Part II Employee Offer of Coverage S 5 State or province Jan 2C 7 Street address (including apartment no.) Z 8 All 12 Months Part I Employee 1 Main Street Apt A Internal Revenue Service Richard Gilbert Name of employee EAST BETHEL 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

**Covered Individuals** 

Part III

	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	d coverage, check the	e box and enter the	e informatio	on for ea	ch indi	vidual e	nrolled	in cove	rage, in	cluding	the en	ployee			
(a)	(a) Name of covered individual(s)	(b) SSN or other TIN	or other TIN is	(d) Covered					<b>e</b>	ਰ ⊦	Coverage	İ				
				all 12 months	Jan	Feb	Mar	Apr	Мау	June	July	Aug	Sept	Oct	Nov	Dec
17																
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22																

Form 1095-C (2016)

Cat. No. 60705M

Twin City Mechanical Testing Street Suite T ABBEVIĽLE, AL, 12345

### Instructions for Recipient

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

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

#### Part I. Employee.

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

## Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for states single federal poverty line) and minimum essential coverage offered to your spouse and contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous 14. Minimum essential coverage providing minimum value offered to you with an employee all 12 months of the calendar year.
- 1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s)
- 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) coverage offered to your dependent(s) and spouse.
  - You were NOT a full-time employee for any month of the calendar year but were enrolled in 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

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

Donovan Hall 1 Main Street Apt A SHAFER, MN, 55074 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10)

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

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

### Part III. Covered Individuals, Lines 17-22

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

Form 1095-C Department of the Treasury Internal Revenue Service

# Employer-Provided Health Insurance Offer and Coverage ▶ Do not attach to your tax return. Keep for your records.

OMB No. 1545-2251	2016
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▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1099

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1 Name of employee			2 Socia	2 Social security number (SSN)	(SSN)	7 Name of employer	employer						8 Emp	oloyer ide	8 Employer identification number (EIN)	equinu u	r (EIN)
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3 Street address (including apartment no.)	uding apartment no.)					9 Street address (including room or suite no.)	dress (incl	uding roo	m or suite	no.)			<b>10</b> Con	tact telep	10 Contact telephone number	nber	
1 Main Street Apt A	ot A					1 Testing Street Suite T	y Street	Suite 7	_					156	561656066	99	
4 City or town	5 State or province	90	6 Count	6 Country and ZIP or foreign postal code	n postal code	11 City or town	uwo		42	State or province	ince		<b>13</b> Cour	try and Z	13 Country and ZIP or foreign postal code	gn postal	code
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Part    Emplo	<b>Employee Offer of Coverage</b>	ige				Plan Start Month (Enter 2-digit number): 10	art Mor	ith (Ente	er 2-dig	it numb	er): 10						
	All 12 Months Jan	Feb	Mar	Apr	May	June		July	Aug	Ð	Sept		Oct	Ž	Nov	Dec	ပ
14 Offer of Coverage (enter required code)	1A	1A	1A	1A	1A	1H		Ħ H	7	1H	H H		1H		1H	H H	_
15 Employee Required Contribution (see instructions)	\$	↔	↔	₩	\$	↔	↔		₩	0,	€	₩		₩		₩	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C	2C	2C	2C	5C	2A		2A		2A	2A		2A	7	2A	2A	_
Part III Covere	<b>Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	ed coverag	e, check the	box and enter	r the inform	nation for e	each ind	ividual e	enrolled	in cove	rage, inc	cluding	the emp	oloyee.			
o Jo emely (e)	(a) Name of covered individual(e)	(h) CONIC	NIT yetto you of NIN	(c) DOB (If SSN		red				(e)	(e) Months of Coverage	Soverage					
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For Privacy Act and	For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ct Notice, se	e separate i	nstructions.				Cat. N	Cat. No. 60705M						Form <b>1</b> (	Form <b>1095-C</b> (2016)	(2016)

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

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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec OMB No. 1545-2251 6 10 Contact telephone number 13-1321616 1561656066 ↔ 8 8 S Applicable Large Employer Member (Employer) 12345 CORRECTED ö S VOID Plan Start Month (Enter 2-digit number): 10 Sept 12 State or province ᡐ 9 Street address (including room or suite no.) Aug **Employer-Provided Health Insurance Offer and Coverage** ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c 8 1 Testing Street Suite T Twin City Mechanical July 7 Name of employer <del>()</del> ▶ Do not attach to your tax return. Keep for your records. ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June S May 2 Social security number (SSN) ᡐ \*\*\*\*\*0014 Apr S 55303 Mar 8 Feb Part II Employee Offer of Coverage S 5 State or province Jan Part III Covered Individuals 3 Street address (including apartment no.) Z Z 8 All 12 Months 2H 1 Part | Employee 1 Main Street Apt A **1095-C** Department of the Treasury Internal Revenue Service Nancy lacarella 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) NOWTHEN 4 City or town

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

Twin City Mechanical

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ABBEVIĽLE, AL, 12345

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Department of the Treasury Internal Revenue Service 1095-C

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

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

Part   Employee	loyee							Appli	Applicable Large Employer Member (Employer)	arge E	:mplo	rer Mer	nber (	Emplo	yer)			
1 Name of employee	Φ			2 Soci	Social security number (SSN)	ır (SSN)	7 Name o	7 Name of employer	,					<b>8</b> Д	nployer id	8 Employer identification number (EIN)	n number	r (EIN)
Brandon Jenc					*****0015	2	Twin City Mechanical	ty Mech	anical						13	13-1321616	16	
3 Street address (including apartment no.)	cluding apartm	lent no.)					9 Street a	9 Street address (including room or suite no.)	sluding roc	om or suit	e no.)			<b>10</b> C	ontact tele	10 Contact telephone number	mber	
1 Main Street Apt A	İ						$\overline{}$	g Stree	t Suite	_					15	1561656066	99(	
4 City or town	4/	5 State or province	псе	6 Country ar	itry and ZIP or forei	nd ZIP or foreign postal code	11 City or town	town		12 St	12 State or province	/ince		<b>13</b> ე	untry and	13 Country and ZIP or foreign postal code	ign postal	code
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	All 12 Months	Jan	Feb	Mar	Apr	May	June	ā	July	A	Aug	Sept		Oct		Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A		14		1A	1A		1A		1A	1A	
15 Employee Required Contribution (see instructions)	₩	↔	↔	↔	₩	↔	₩	₩		₩		€	↔		₩		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	ZA	2D	2D	2D	2C		2C	2	2C	2C		2C	.,	2C	2C	
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omeN (e)	(a) Name of covered individual(a)	doli polici)	(A)	NIT redto to NSS (4)	(c) DOB (If SSN	SN (d) Covered	ered				(e)	(e) Months of Coverage	Coverag	Ф				
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Phillip Johnson 1 Main Street Apt A BLAINE, MN, 55434

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

OMB No. 1545-2251	9108
<u> </u>	CORRECTED

VOID

Employer-Provided Health Insurance Offer and Coverage

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1 Name of employee	99/			2 Soc	2 Social security number (SSN)	oer (SSN)	7 Name of employer	yer			8 Emp	8 Employer identification number (EIN)	number (ΕΙΝ)
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3 Street address (including apartment no.)	including apartr	ment no.)					9 Street address (including room or suite no.)	(including room	n or suite no.)		10 Con	10 Contact telephone number	mber
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4 City or town		5 State or province	псе	<b>6</b> Cou	6 Country and ZIP or foreign postal code 11 City or town	eign postal code	11 City or town		12 State or province	ovince	13 Cour	13 Country and ZIP or foreign postal code	gn postal code
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	All 12 Months	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	₩.	\$	₩	↔	\$	<del>∨</del>	↔	₩	↔	↔	↔	₩	₩
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### Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury

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

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

OMB No. 1545-2251 CORRECTED VOID

8 Employer identification number (EIN) ဝဓိ 13 Country and ZIP or foreign postal code Dec Dec 6 10 Contact telephone number  $\frac{3}{2}$ 13-1321616 1561656066 ↔ ö 8 8 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. Sept S Applicable Large Employer Member (Employer) 12345 oct Aug (e) Months of Coverage ↔ July Plan Start Month (Enter 2-digit number): 10 Sept June 12 State or province ↔ May 9 Street address (including room or suite no.) Aug ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c Apr 8 1 Testing Street Suite T Twin City Mechanical Mar July 7 Name of employer Feb <del>()</del> ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June Jan <del>()</del> (d) Covered all 12 months May 2 Social security number (SSN) ᡐ (c) DOB (If SSN or other TIN is not available) \*\*\*\*\*0017 Apr S 55110 Mar (b) SSN or other TIN 8 Feb Employee Offer of Coverage 8 5 State or province Jan **Covered Individuals** (a) Name of covered individual(s) Street address (including apartment no.) Z 8 All 12 Months 1 2H WHITE BEAR LAKE Part | Employee 1 Main Street Apt A Internal Revenue Service Richard Kiesling Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town Part II Part III 8 19 1 20

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

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Cat. No. 60705M

Form 1095-C (2016)

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

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	Covered Individuals	مامرام											

16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

Part III

14 Offer of Coverage (enter required code)
15 Employee Required Contribution (see instructions)

Part III				<u>.</u>	. <u>&amp;</u>	19	50	2	8
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) Nome of convey for individual (c)	(a) Naille Of COVERED III (MADA(S)						
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Form 1095-C (2016)

Cat. No. 60705M

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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Form 1095-C
Department of the Treasury

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

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**1095-C** Department of the Treasury Internal Revenue Service

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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 1 2A 10 Contact telephone number 13-1321616 1561656066 ↔ 8 8 1 2A S Applicable Large Employer Member (Employer) 12345 ö 1 2A ᡐ Plan Start Month (Enter 2-digit number): 10 Sept 14 2H 12 State or province ↔ 9 Street address (including room or suite no.) Aug 2D 1 ₩ 1 Testing Street Suite T Twin City Mechanical July 2D 1 7 Name of employer <del>()</del> ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June 2D 1 S 2A May 1 2 Social security number (SSN) ᡐ \*\*\*\*\*0021 Apr 1 2A S 55337 Mar 1 2A 8 Feb 1 **2**A Part II Employee Offer of Coverage S 5 State or province Jan 1 2A Part III Covered Individuals Street address (including apartment no.) Z 8 All 12 Months Part | Employee 1 Main Street Apt A 1 Name of employee BURNSVILLE 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) **Gerald Paul** 4 City or town

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	If Employer provided self-insured coverag	e, check t	he box and enter the	e informatio	in for each individual enrolled in coverage, including the employee. $\ oxdot$
	(a) Name of covered individual(e)	(b) SSN or other TIN	(c) DOB (If SSN	(d) Covered	(e) Months of Coverage
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Michael Poppler 1 Main Street Apt A SO ST PAUL, MN, 55075

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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### Part III. Covered Individuals, Lines 17-22

Form **1095-C**Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

P 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

OMB No. 1545-2251	2016
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Part   Empl	Employee							Applic	able La	Applicable Large Employer Member (Employer)	oloyer M	ember	(Emplo	yer)		
1 Name of employee	Φ			2 Socia	Social security number (SSN)	(SSN)	7 Name of employer	employer					<b>8</b>	mployer ic	dentificatio	8 Employer identification number (EIN)
Michael Poppler	ler				*****0022		Twin City Mechanical	y Mecha	anical					13	3-1321616	16
3 Street address (including apartment no.)	cluding apartme	ent no.)					9 Street ac	dress (incl	uding roon	9 Street address (including room or suite no.)			10 C	ontact tel	10 Contact telephone number	nber
1 Main Street Apt A	4pt A						1 Testing	<b>Testing Street Suite</b>	Suite T					15	1561656066	99
4 City or town	5	5 State or province	Jce .	6 Country	try and ZIP or foreign postal code	yn postal code	11 City or town	nwo		12 State o	State or province		13 C	ountry and	ZIP or forei	13 Country and ZIP or foreign postal code
SO ST PAUL	2	NΝ		55075	10		ABBEVILLE	LLE		AL			12345	45		
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	All 12 Months	Jan	Feb	Mar	Apr	May	June		July	Aug	Sept	#	Oct		Nov	Dec
14 Offer of Coverage (enter required code)		芒	두	羊	H H	TA AL	1A		41 41	4T	A1	4	1 <sub>A</sub>		1A	4T
	₩	₩	↔	₩.	₩.	↔	↔	↔		₩	₩	₩		↔		₩
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2H	2H		2H	2H	2H	т	2C		2C	2C
Part III Cove	Covered Individuals If Employer provided se	<b>duals</b> Jed self-insu	ıred covera <u>ç</u>	je, check th∈	<b>Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	r the inform	ation for 6	each indi	ividual e	nrolled in	coverage,	includin	g the er	nployee		
	1000		100	NI   1	SS JI) BÖB (b)	N (d) Covered	red				(e) Months of Coverage	of Covera	ge			
(a) Name (	(a) Name of covered individual(s)	/idual(s)	Nico (a)	(b) SSN or otner LIN	or other IIN is not available)		nths Jan	Feb	Mar	Apr May	ly June	July	Ang	Sept	Oct	Nov Dec
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Form 1095-C (2016)

Cat. No. 60705M

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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1095-C Department of the Treasury Internal Revenue Service

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

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MB No. 1545-2251 

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8 Employer identification number (EIN) Dec 13 Country and ZIP or foreign postal code Dec Dec 1 2A 10 Contact telephone number  $\frac{3}{2}$ 13-1321616 1561656066 ↔ ö <u>8</u> 7 2C If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. Sept S Applicable Large Employer Member (Employer) 12345 oct 1 2C Aug (e) Months of Coverage ↔ July Plan Start Month (Enter 2-digit number): 10 Sept 2D 1 June 12 State or province ↔ May 9 Street address (including room or suite no.) Aug 2D 1 Apr ₩ 1 Testing Street Suite Twin City Mechanical Mar July 2D 1 7 Name of employer ₩ Feb ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June 1 **2A** Jan <del>()</del> (d) Covered all 12 months May 2A 1 2 Social security number (SSN) ↔ (c) DOB (If SSN or other TIN is not available) \*\*\*\*\*0023 Apr 廾 2A ↔ 55432 Mar (b) SSN or other TIN 1 2A 8 Feb 1 2A Part II Employee Offer of Coverage <del>()</del> 5 State or province Jan 1 2A **Covered Individuals** (a) Name of covered individual(s) Street address (including apartment no.) <del>()</del> All 12 Months Part I Employee 1 Main Street Apt A S Jason Reichert Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town FRIDLEY Part III 8 19 ដ 1 20 7

Form 1095-C (2016)

Cat. No. 60705M

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

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  - IE. Milling in essential coverage providing milling value orieted to you and milling essential coverage offered to your dependent(s) and spouse.
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Department of the Treasury Internal Revenue Service 1095-C

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	OMB No. 1545-225	9102
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Part   Employee	oloyee						Ap	plicable La	Applicable Large Employer Member (Employer)	yer Membe	ər (Employe	er)	
1 Name of employee	,66			2 Social	2 Social security number (SSN)	(NSS)	7 Name of employer	oyer			8 Empl	8 Employer identification number (EIN)	n number (EIN)
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3 Street address (including apartment no.)	including apartm	ent no.)					9 Street address (including room or suite no.)	s (including roon	or suite no.)		<b>10</b> Cont	10 Contact telephone number	mber
1 Main Street Apt A	Apt A						1 Testing Street Suite T	reet Suite T				1561656066	99
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Part    Emp	oloyee Offe	<b>Employee Offer of Coverage</b>	age				Plan Start Month (Enter 2-digit number): 10	<b>Month</b> (Ente	r 2-digit num	ber): 10			
	All 12 Months	Jan	Feb	Mar	Apr	Мау	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	Ŧ	Ŧ	Ŧ	푸	1H	Ħ	H.	Ŧ	푸	H.	<u> </u>
15 Employee Required Contribution (see instructions)	₩	<del>\$</del>	↔	₩	\$	↔	\$	₩	\$	\$	₩	\$	↔
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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(a) Name of covered individual	MIT 20 450 SON OF CAN	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	f Coveraç	je je				
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Form **1095-C** (2016)

Cat. No. 60705M

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

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rance Offer and Coverage

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ran Emp	Employee							Applicable Large Employer Member (Employer)	able La	arge El	mploye	∍r Men	per (E	mploy	er)			
1 Name of employee	,66			2 Social sec			7 Name of employer	əmployer						<b>8</b> Emp	8 Employer identification number (EIN)	ntificatio	า number	(EIN)
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3 Street address (including apartment no.)	including apartm	nent no.)					9 Street address (including room or suite no.)	dress (inclu	uding roor	n or suite	no.)			<b>10</b> Cor	10 Contact telephone number	hone nui	nber	
1 Main Street Apt A	Apt A						1 Testing Street Suite	Street	Suite T						156	1561656066	99	
4 City or town		5 State or province	Se	6 Countr	6 Country and ZIP or foreign postal code		11 City or town	wn		12 Stat	12 State or province	JCe		<b>13</b> Cou	13 Country and ZIP or foreign postal code	IP or forei	yn postal c	ode
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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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ABBEVIĽLE, AL, 12345

Testing Street Suite T

Twin City Mechanical

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**1095-C** Department of the Treasury Internal Revenue Service

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c ▶ Do not attach to your tax return. Keep for your records.

OMB No. 1545-2251	2016
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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 10 Contact telephone number 13-1321616 1561656066 ↔ 8 8 S Applicable Large Employer Member (Employer) 12345 ö S Plan Start Month (Enter 2-digit number): 10 Sept 12 State or province ↔ 9 Street address (including room or suite no.) Aug <del>()</del> 1 Testing Street Suite T Twin City Mechanical July 7 Name of employer <del>()</del> ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June S May 2 Social security number (SSN) ᡐ \*\*\*\*\*0027 Apr S 55110 Mar <del>()</del> Feb WHITE BEAR LAKE | MN | Part II | Employee Offer of Coverage S 5 State or province Jan 16 Section 4980H
Safe Harbor and
Other Relief (enter code, if applicable)

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Covered Individuals 3 Street address (including apartment no.) ↔ All 12 Months 1 Part | Employee 1 Main Street Apt A 1 Name of employee Robert Skeie 14 Offer of
Coverage (enter
required code)
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Required
Contribution (see
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	If Employer provided self-insured coverage, chec	d coverage, check the	ck the box and enter the information for each individual enrolled in coverage, including the employ	e informatio	n for each ir	ndividual enr	olled in co	/erage, ir	cluding	the en	ployee	
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Jamie Swan 1 Main Street Apt A

EAGAN, MN, 55121

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1095-C Department of the Treasury Internal Revenue Service

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

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Form 1095-C (2016)

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**1095-C** Department of the Treasury

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

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ii Enipioyer provided seii-insured coverage, check ure box and enier ure iniorniauon for each individual enrolled in coverage, including ure employee.	(a) Nome of constraint individual (a)	(a) Marine Of Covered individual(s)	21	18	19	20	21	22	For Privacy Act and Paperwork Reduction Act Notice, see separate inst

Cat. No. 60705M

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

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

#### Part I. Employee.

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

## Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for states single federal poverty line) and minimum essential coverage offered to your spouse and contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous 14. Minimum essential coverage providing minimum value offered to you with an employee all 12 months of the calendar year.
- 1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential
- 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse coverage offered to your spouse but NOT your dependent(s)
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
  - 1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This spouse or dependent(s), or you, your spouse, and dependent(s)
    - 1H. No offer of coverage (you were NOT offered any health coverage or you were offered code will be entered in the All 12 Months box on line 14.
- month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one

coverage that is NOT minimum essential coverage).

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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

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

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

### Part III. Covered Individuals, Lines 17-22

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

Department of the Treasury Internal Revenue Service **1095-C** 

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

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

OMB No. 1545-2251	9102
<u> </u>	CORRECTED

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

Part   Employee	oloyee							Ap	Applicable Large Employer Member (Employer)	arge Emplo	yer Membe	er (Employ	er)	
1 Name of employee	99.				2 Social	2 Social security number (SSN)	r (SSN)	7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	n number (EIN)
Anna Wicks						*****0031		Twin City Mechanical	echanical				13-1321616	16
3 Street address (including apartment no.)	ncluding apartm	nent no.)						9 Street address (including room or suite no.)	s (including roon	n or suite no.)		<b>10</b> Con	10 Contact telephone number	mber
1 Main Street Apt A	Apt A							1 Testing Street Suite 1	reet Suite T				1561656066	99
4 City or town		5 State or province	ince		6 Country	and ZIP or foreig	gn postal code	6 Country and ZIP or foreign postal code 11 City or town		12 State or province	ovince	<b>13</b> Cour	13 Country and ZIP or foreign postal code	gn postal code
WHITE BEAR TWSP   MN	TWSP I	ZZ			55110			ABBEVILLE		AL		12345	10	
Part II Employee Offer of Coverage	oloyee Offe	∍r of Cover	age,					Plan Start Month (Enter 2-digit number): 10	<b>Month</b> (Ente	r 2-digit nun	iber): 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 Cov	Covered Individuals If Employer provided se	iduals	ired coverag	G	heck the k	and ente		<b>Covered Individuals</b> If Employer provided self-insured coverage, check the hox and enter the information for each individual enrolled in coverage, including the employee	e le lodividual e	orolled in co.	verage includ	ling the emr		
j :	75.7	50.50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, (5)		313 500		220 20 20 20 20 20 20 20 20 20 20 20 20	355555	)) -= 50=0	2 280,	7 O.:. D	3	

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each
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(a) Interpolate processor to comply (c)	(b) CCNI or other TINI	(c) DOB (If SSN	(d) Covered					<b>©</b>	(e) Months of Coverage	f Covera	ge				
(a) Mairie of covered individual(s)		or other rin is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ot Notice, see separate	instructions.		_		Cat. N	Cat. No. 60705M	5					Form	1095-	Form <b>1095-C</b> (2016)

Cat. No. 60705M

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. 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 voir spouse.
  - coverage offered to your dependent(s) but NOT your spouse.

    1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
  - 1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
    1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This
- code will be entered in the All 12 Months box on line 14.

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

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

Twin City Mechanical

Testing Street Suite T

ABBEVIĽLE, AL, 12345

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

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

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

### Part III. Covered Individuals, Lines 17-22

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

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251	2016
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Internal Revenue Service	rvice	▶ Info	▶ Information about Form 1095-C	out Forr	n 1095-C	and its sepa	rate instruc	and its separate instructions is at www.irs.gov/form1095c	v.irs.gov/form	1095c				
Part   Employee	oloyee							Ap	Applicable Large Employer Member (Employer)	arge Emplo	yer Memb	er (Employ	er)	
1 Name of employee	ee				2 Social s	2 Social security number (SSN)	r (SSN)	7 Name of employer	oloyer			8 Emp	8 Employer identification number (EIN)	n number (EIN)
Melinda Wisgerhof	lerhof					*****0032	2	Twin City Mechanical	echanical				13-1321616	16
3 Street address (including apartment no.)	ncluding apartm	nent no.)						9 Street address (including room or suite no.)	ss (including roor	n or suite no.)		10 Cont	10 Contact telephone number	mber
1 Main Street Apt A	Apt A							1 Testing Street Suite 1	reet Suite T				1561656066	990
4 City or town		5 State or province	ince		6 Country	and ZIP or foreig	gn postal code	6 Country and ZIP or foreign postal code 11 City or town		12 State or province	ovince	<b>13</b> Coun	13 Country and ZIP or foreign postal code	gn postal code
WHITE BEAR TWSP MN	TWSP N	ΝN			55110			ABBEVILLE		AL		12345	2	
Part   Employee Offer of Coverage	oloyee Offe	er of Cover	rage	*				Plan Start Month (Enter 2-digit number): 10	<b>Month</b> (Ente	ır 2-digit nun	10 (Jper): 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)	2Н													
Part III Covered Individuals	ered Indivi	iduals			-1			-						
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(a) Ivalile of covered individual(s)	(b) SON OF OTHER TIEN	or otner IIIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
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For Privacy Act and Paperwork Reduction Act Notice, see separate instr	ct Notice, see separate i	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)