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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.

Rodger r Fawley
560 W Kirkland Street
BUTLER, PA, 16001

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

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)
Rodger r Fawley	*****8792
3 Street address (including apartment no.)	
560 W Kirkland Street	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
BUTLER	PA	16001

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	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	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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).
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June Lamoureux
8067 Tanglewood Street
CORONA, NY, 11368

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

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)
June Lamoureux	*****9632
3 Street address (including apartment no.)	
8067 Tanglewood Street	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
CORONA	NY	11368

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	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	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2C	2C	2C	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											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Jordon g Eichorn
8332 Harvard Lane
SHEBOYGAN, WI, 53081

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)
Jordon g Eichorn	*****5576
3 Street address (including apartment no.)	
8332 Harvard Lane	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
SHEBOYGAN	WI	53081

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$	$	$	$	$
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	Jordon g Eichorn	*****5576	03-19-1994	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	Maggie Eichorn	*****4789		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19	Jason Eichorn	*****6439		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	Brock Eichorn	*****1724		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21	Lucy Eichorn	*****8683		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22	Jordon Eichorn Jr	*****3103		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Name of employee | Social security number (SSN)

Part III Covered Individuals — Continuation Sheet

	(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	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23	Kerrigan Eichorn	*****0770		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Chris t Borkowski Jr
9538 Applegate St
HERNANDO, MS, 38632

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)
Chris t Borkowski Jr	*****9116

3 Street address (including apartment no.)
9538 Applegate St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
HERNANDO	MS	38632

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212

9 Street address (including room or suite no.)	10 Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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.
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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 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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Ruthanne f Tomey
449 West Rose Street Apt 18
AMBLER, PA, 19002

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)
Ruthanne f Tomey	*****7410
3 Street address (including apartment no.)	
449 West Rose Street Apt 18	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
AMBLER	PA	19002

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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.
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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 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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Dominga j Lapp
30 East Fawn Street
MOUNT HOLLY, NJ, 08060

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)
Dominga j Lapp	*****4075
3 Street address (including apartment no.)	
30 East Fawn Street	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
MOUNT HOLLY	NJ	08060

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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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Part I. Applicable Large Employer Member (Employer)

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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.
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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Melda e Mirabella
7568 Ohio Lane
WILSON, NC, 27893

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)
Melda e Mirabella	*****5522
3 Street address (including apartment no.)	
7568 Ohio Lane	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
WILSON	NC	27893

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Ivan d Ostroff
193 Manhattan St
OPA LOCKA, FL, 33054

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)
Ivan d Ostroff	*****0102

3 Street address (including apartment no.)
193 Manhattan St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
OPA LOCKA	FL	33054

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212

9 Street address (including room or suite no.)	10 Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
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	Ivan d Ostroff	*****0102	04-16-1998	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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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.
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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Roxanna d Dacus
47 Westport Street
NEW BRUNSWICK, NJ, 08901

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)
Roxanna d Dacus	*****9266
3 Street address (including apartment no.)	
47 Westport Street	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
NEW BRUNSWICK	NJ	08901

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C				2B	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	Roxanna d Dacus	*****9266	09-16-1983	☐	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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.
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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).
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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Maren e Fuqua
88 Ashley Drive
BLACKWOOD, NJ, 08012

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)
Maren e Fuqua	*****5601

3 Street address (including apartment no.)
88 Ashley Drive

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
BLACKWOOD	NJ	08012

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212

9 Street address (including room or suite no.)	10 Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
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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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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Cory g Plant
9622 Winchester Road
EASTON, PA, 18042

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)
Cory g Plant	*****4865
3 Street address (including apartment no.)	
9622 Winchester Road	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
EASTON	PA	18042

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 91.00	$ 91.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)				2B	2A	2D	2D	2D	2D	2D	2D	2D	2D

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

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Lise y Lemasters Sr
8767 Rose Avenue
BRANFORD, CT, 06405

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 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)
Lise y Lemasters Sr	*****5779
3 Street address (including apartment no.)	
8767 Rose Avenue	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
BRANFORD	CT	06405

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

King d Pier
209 Country Club Ave Apt B
GLEN COVE, NY, 11542

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)
King d Pier	*****5606

3 Street address (including apartment no.)
209 Country Club Ave Apt B

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GLEN COVE	NY	11542

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212

9 Street address (including room or suite no.)	10 Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

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

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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).
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AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Arlyne d Mccolley
98 Glenridge Court
WOODSIDE, NY, 11377

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)
Arlyne d Mccolley	*****7557

3 Street address (including apartment no.)
98 Glenridge Court

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
WOODSIDE	NY	11377

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212

9 Street address (including room or suite no.)	10 Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$ 91.00	$ 91.00	$ 91.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D				2B	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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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.

Lashanda b Horiuchi
258 Oak Meadow Avenue
LANSDOWNE, PA, 19050

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

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)
Lashanda b Horiuchi	*****5737
3 Street address (including apartment no.)	
258 Oak Meadow Avenue	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
LANSDOWNE	PA	19050

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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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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.
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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).
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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.

Alaine a Lemaster
858 Wentworth Lane
RALEIGH, NC, 27603

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

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)
Alaine a Lemaster	*****3448
3 Street address (including apartment no.)	
858 Wentworth Lane	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
RALEIGH	NC	27603

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	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	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2D						

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).
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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).
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AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Maryjane h Feldmann
9109 Maple Ave
CLARKSTON, MI, 48348

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)
Maryjane h Feldmann	*****6742
3 Street address (including apartment no.)	
9109 Maple Ave	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
CLARKSTON	MI	48348

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 91.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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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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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.

AmandaB
5 Crazy Street
RUSSELLVILLE, SC, 29302

Ernie n Lamoureux
8067 Tanglewood Street
CORONA, NY, 11368

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)
Ernie n Lamoureux	*****1854
3 Street address (including apartment no.)	
8067 Tanglewood Street	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
CORONA	NY	11368

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AmandaB	22-2222212
9 Street address (including room or suite no.)	**10** Contact telephone number
5 Crazy Street	5551112222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
RUSSELLVILLE	SC	29302

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 02

	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	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00	$ 91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2B	2C	2C	2C	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	Ernie n Lamoureux	*****1854	08-06-1991	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
18	June Lamoureux	*****9632		☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐