# Instructions for Recipient

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## 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.

Test Sanjay
456 789
ANTHONY, FL, 65465

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.**
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☐ 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) |
|---|---|
| Test Sanjay | 11-5464646 |
| **9** Street address (including room or suite no.) | **10** Contact telephone number |
| 456 789 | 5464646464 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
|---|---|---|
| ANTHONY | FL | 65465 |

## Part II Employee Offer of Coverage

**Plan Start Month** (Enter 2-digit number): 06

| | 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) | | 2D | 2D | 2D | 2F | 2F | 2F | 2F | 2F | 2F | 2F | 2F | 2F |

## 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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Test Sanjay
456 789
ANTHONY, FL, 65465

Taina d Pier
209 Country Club Ave
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.**

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☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2016**

## Part I Employee

| 1 Name of employee | 2 Social security number (SSN) |
|---|---|
| Taina d Pier | *****6949 |
| **3** Street address (including apartment no.) | |
| 209 Country Club Ave | |

| 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) |
|---|---|
| Test Sanjay | 11-5464646 |
| **9** Street address (including room or suite no.) | **10** Contact telephone number |
| 456 789 | 5464646464 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
|---|---|---|
| ANTHONY | FL | 65465 |

## Part II Employee Offer of Coverage

**Plan Start Month** (Enter 2-digit number): 06

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **14** Offer of Coverage (enter required code) | 1H | | | | | | | | | | | | |
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## Part III Covered Individuals

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| 17 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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Test Sanjay
456 789
ANTHONY, FL, 65465

Suresh u Benoit
33 Pawnee Ave
RAPID CITY, SD, 57701

600117

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

# Employer-Provided Health Insurance Offer and Coverage

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☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2016**

## Part I Employee

| 1 Name of employee | 2 Social security number (SSN) |
|---|---|
| Suresh u Benoit | *****5566 |

| 3 Street address (including apartment no.) |
|---|
| 33 Pawnee Ave |

| 4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code |
|---|---|---|
| RAPID CITY | SD | 57701 |

## Applicable Large Employer Member (Employer)

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| Test Sanjay | 11-5464646 |

| 9 Street address (including room or suite no.) | 10 Contact telephone number |
|---|---|
| 456 789 | 5464646464 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
|---|---|---|
| ANTHONY | FL | 65465 |

## Part II Employee Offer of Coverage

**Plan Start Month** (Enter 2-digit number): 06

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **14** Offer of Coverage (enter required code) | 1H | | | | | | | | | | | | |
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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| 17 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
**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.

Test Sanjay
456 789
ANTHONY, FL, 65465

Clarice e Mirabella
7568 Ohio Lane Apt 19
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) |
|---|---|
| Clarice e Mirabella | *****1195 |
| **3** Street address (including apartment no.) | |
| 7568 Ohio Lane Apt 19 | |

| 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) |
|---|---|
| Test Sanjay | 11-5464646 |
| **9** Street address (including room or suite no.) | **10** Contact telephone number |
| 456 789 | 5464646464 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
|---|---|---|
| ANTHONY | FL | 65465 |

## Part II Employee Offer of Coverage

**Plan Start Month** (Enter 2-digit number): 06

| | 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) | 2F | | | | | | | | | | | | |

## 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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**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.

Test Sanjay
456 789
ANTHONY, FL, 65465

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

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) |
|---|---|
| Lisenew ne Lemastersnew Sr | *****4514 |
| **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 | 64055 |

## Applicable Large Employer Member (Employer)

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| Test Sanjay | 11-5464646 |
| **9** Street address (including room or suite no.) | **10** Contact telephone number |
| 456 789 | 5464646464 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
|---|---|---|
| ANTHONY | FL | 65465 |

## Part II Employee Offer of Coverage

**Plan Start Month** (Enter 2-digit number): 06

| | 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) | | 2D | 2D | 2F | 2F | 2F | 2F | 2F | 2F | 2F | 2F | 2F | 2F |

## 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 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |