Testing Non Employees 1 Testing Street Suite T ABBEVILLE, AL, 12345

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Instructions for Recipient

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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Bob Smith 5 Orange Lane Greer, SC, 29650 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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1095-C Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

| OMB No. 1545-2251 | 2016 |
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8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 2C 7 10 Contact telephone number 6561619809 12-5891661 S X 8 8 7 2C S Applicable Large Employer Member (Employer) 12345 oct 7 2C ᡐ Sept **2**G 7 12 State or province Plan Start Month (Enter 2-digit number) ᡐ 9 Street address (including room or suite no.) Aug 2D 1 8 **Testing Non Employees** 1 Testing Street Suite T July 2D 1 7 Name of employer () ABBEVILLE 6 Country and ZIP or foreign postal code 11 City or town June 1 **2A** S 2A May 1 2 Social security number (SSN) ᡐ *****6123 Apr 1 2A S 29650 Маг 1 2A 8 Feb 1 2A Part II Employee Offer of Coverage S 5 State or province Jan 1 2A 3 Street address (including apartment no.) 8 All 12 Months Part | Employee 1 Name of employee 5 Orange Lane 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) Bob Smith 4 City or town

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. **Covered Individuals** Part III

| (A) or this ibail began to be comply (a) | NIT TO THE TO NO (1) | (c) DOB (If SSN | (d) Covered | | | | | (e) MG | nths of C | (e) Months of Coverage | | | | | |
|--|--------------------------|------------------------------------|---------------|-----|-----|---------|-----------------|--------|-----------|------------------------|-----|------|------|--------------------|----------|
| (a) Name of covered individual(s) | (b) SON OF OTHER THA | or otner IIIN IS not available) | all 12 months | Jan | Feb | Mar | Apr | May J | June | July | Aug | Sept | Oct | Nov | Dec |
| 17 Bob Smith | ******6123 | | | | | | | | | | | X | X | X | \times |
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| For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. | t Notice, see separate i | nstructions. | | - | _ | Cat. No | Cat. No. 60705M | | - | | | | Form | Form 1095-C (2016) | (2016) |

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Employer-Provided Health Insurance Offer and Coverage

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| Form FC C C Department of the Treasury Internal Revenue Service | asury ice | ▼ Infor | ► Do not attach to your life with the young life with the | Do not atta Form 1095 | | tax return. | Keep fo | ► Do not attach to your tax return. Keep for your records. out Form 1095-C and its separate instructions is at www.irs.gov/form1095c | s. .irs.gov/form | 11095c | 00 | CORRECTED | 8 | 2016 |
| Part Employee | oyee | | | | | | | Ap | plicable La | arge Emp | Applicable Large Employer Member (Employer) | ber (Emple | yer) | |
| 1 Name of employee | 0 | | | 2 Soc | ial security r | 2 Social security number (SSN) | | 7 Name of employer | oyer | | | 8 | 8 Employer identification number (EIN) | tion number (EII) |
| Sally Johnnson | _ | | | | * * * * | 6829**** | | Testing Non Employees | Employee | S | | | 12-5891661 | 1661 |
| 3 Street address (including apartment no.) | sluding apartm | nent no.) | | | | | | 9 Street address (including room or suite no.) | s (including roor | m or suite no.) | _ | 10 C | 10 Contact telephone number | number |
| 1 Main St Apt 1 | _ | | | | | | | 1 Testing Street Suite 1 | reet Suite 1 | _ | | | 6561619809 | 6086 |
| 4 City or town | 47 | 5 State or province | nce | 6 Cour | 6 Country and ZIP | or foreign post | al code 1 | IP or foreign postal code 11 City or town | | 12 State or province | . province | 13 C | 13 Country and ZIP or foreign postal code | reign postal code |
| Greer | <u> </u> | SC | | 29650 | 0 | | 7 | ABBEVILLE | | AL | | 12345 | 45 | |
| Part II Empl | oyee Offe | Employee Offer of Coverage | age | | | | | Plan Start Month (Enter 2-digit number): 12 | Month (Ente | er 2-digit n | umber): 12 | | | |
| | All 12 Months | Jan | Feb | Mar | Apr | | May | June | July | Ang | Sept | Oct | Nov | Dec |
| 14 Offer of Coverage (enter required code) | 16 | | | | | | | | | | | | | |
| 15 Employee Required Contribution (see instructions) | ↔ | ₩ | ↔ | ↔ | ₩ | ↔ | | ↔ | ↔ | ↔ | ₩ | ₩ | ₩. | ↔ |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | | | | | | | | | | | | | |
| Part III Cove | Covered Individuals | duals | - | | - | - | | | | - | - | - | | |

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

| /-/ /- : : : : : : : - y / - / - / - / - / - / - / - | 14.F | | (d) Covered | | | | | (<u>C</u> | (e) MOULINS OF COVERAGE | - COVE 18 | Ď. | | | | |
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| (a) Name of covered individual(s) | (a) SSIN OF OTHER TIIN | or otner TIN IS not available) | all 12 months | Jan | Feb | Mar | Apr | May | June | July | Ang | Sept | Oct | Nov | Dec |
| 17 Sally Johnnson | 6829***** | | X | | | | | | | | | | | | |
| 18 James Johnson | ****4321 | | X | | | | | | | | | | | | |
| 19 Bobby Johnson | 698***** | | | | X | X | X | X | X | X | X | X | X | X | $ $ \times |
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1095-C Department of the Treasury Internal Revenue Service

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Employer-Provided Health In

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15 Employee
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Contribution (see
instructions) 4 City or town

| | eck the box and enter the information for each individual enrolled in coverage, including the employee. $ \overline{\mathbf{X}} $ | (e) Months of Coverage | |
|----------------------------|---|-----------------------------------|---|
| | e informatic | (d) Covered | |
| | box and enter th | (c) DOB (If SSN | 1 |
| | d coverage, check the | (h) SSM or other TIM | |
| Pari Covered Individuals | If Employer provided self-insured coverage, chec | (a) Name of covered individual(e) | |
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| | TIP TIP | F 1 | (a) Covered | | | | | 2 | | 5 | 2 | | | | |
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| 17 Daniel Williams | ****8147 | | X | | | | | | | | | | | | |
| 18 Jessica Williams | 6982**** | | × | | | | | | | | | | | | |
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