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

Andy Na Test Sr 101A A block CAMBRIA, CA, 24566 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

Department of the Treasury Internal Revenue Service

Part | Employee 1095-C

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

| OMB No. 1545-2251 | 9102      |
|-------------------|-----------|
| ]                 | CORRECTED |

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

| Part   Employee  | oloyee                                      |   |             |         |             |                       |                | Ap  | oplicable L       | arge Empl            | oyer Memb     | Applicable Large Employer Member (Employer) | er)                                       |                |
|--|---|---|-------------|---------|-------------|-----------------------|----------------|---|-------------------|----------------------|---------------|---|---|----------------|
| 1 Name of employee   | 99.   |   |             | -       | 2 Social se | security number (SSN) | (NSS)          | 7 Name of employer  | loyer             |                      |               | 8 Emp                                       | 8 Employer identification number (EIN     | number (EIN    |
| Andy Na Test Sr  | Sr  |   |             |         |             | *****                 |                | Sanjay Nine test 2  | test 2            |                      |               |   | 99-4446546                                | 46             |
| 3 Street address (including apartment no.)   | ncluding apartm                             | ent no.)  |             |         |             |                       |                | 9 Street address (including room or suite no.)  | ss (including roc | m or suite no.)      |               | 10 Con                                      | 10 Contact telephone number               | nber           |
| 101A A block   |   |   |             |         |             |                       |                | 456 789   |                   |                      |               |   | 5464646464                                | 64             |
| 4 City or town   | 47  | 5 State or province   | nce         |         | 6 Country a | nd ZIP or foreig      | yn postal code | and ZIP or foreign postal code 11 City or town  |                   | 12 State or province | rovince       | 13 Cou                                      | 13 Country and ZIP or foreign postal code | yn postal code |
| CAMBRIA  | <u> </u>                                    | CA  |             | 2       | 24566       |                       |                | ANTHONY   |                   | 긥                    |               | 65465                                       | 2   |                |
| Part II Employee Offer of Coverage   | oloyee Offe                                 | r of Cover  | age         |         |             |                       |                | Plan Start Month (Enter 2-digit number): 06   | <b>Month</b> (Ent | er 2-digit nu        | mber): 06     |   |   |                |
|  | All 12 Months                               | Jan   | Feb         | _       | Mar         | Apr                   | May            | June  | July              | Aug                  | Sept          | Oct   | Nov                                       | Dec            |
| 14 Offer of<br>Coverage (enter<br>required code)                                   | 土   |   |             |         |             |                       |                |   |                   |                      |               |   |   |                |
| 15 Employee<br>Required<br>Contribution (see<br>instructions)                      | €   | ₩   | ↔           | ↔       | 97          | ↔                     | €9             | ₩   | ↔                 | €                    | €9            | €   | ↔   | ₩              |
| 16 Section 4980H<br>Safe Harbor and<br>Other Relief (enter<br>code, if applicable) | 2F  |   |             |         |             |                       |                |   |                   |                      |               |   |   |                |
| Part III Cov   | Covered Individuals If Employer provided se | Covered Individuals If Employer provided self-insured coverage, check the | ıred covera | ge, che | ck the bo   | ox and ente           | er the inforr  | box and enter the information for each individual enrolled in coverage, including the employee. | h individual      | enrolled in co       | verage, inclu | ding the em                                 | oloyee.                                   |                |

(e) Months of Coverage (d) Covered all 12 months (c) DOB (If SSN or other TIN is (b) SSN or other TIN (a) Name of covered individual(s)

|    | not available) |  | Jan rep | Mar Apr May June July | Apr | May | anne | July | Aug Sept | Sept | OCT NOV | NOV | Dec |
|----|----------------|--|---------|-----------------------|-----|-----|------|------|----------|------|---------|-----|-----|
| 17 |                |  |         |                       |     |     |      |      |          |      |         |     |     |
| 18 |                |  |         |                       |     |     |      |      |          |      |         |     |     |
| 19 |                |  |         |                       |     |     |      |      |          |      |         |     |     |
| 20 |                |  |         |                       |     |     |      |      |          |      |         |     |     |
| 21 |                |  |         |                       |     |     |      |      |          |      |         |     |     |
| 66 |                |  |         |                       |     |     |      |      |          |      |         |     |     |

Form **1095-C** (2016)

Cat. No. 60705M

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

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

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| OMB No. | 20        |
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|         | CORRECTED |

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1545-2251 16

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 10 Contact telephone number 99-4446546 5464646464 ↔ 8 8 S Applicable Large Employer Member (Employer) 65465 ö ᡐ Sept 12 State or province Plan Start Month (Enter 2-digit number): ᡐ 9 Street address (including room or suite no.) Aug 8 July Sanjay Nine test 2 7 Name of employer <del>()</del> 6 Country and ZIP or foreign postal code 11 City or town ANTHONY June 456 789 S May 2 Social security number (SSN) ᡐ \*\*\*\*\* Apr S 24567 Mar 8 Feb CAMBRIA CA S 5 State or province Jan 3 Street address (including apartment no.) 8 All 12 Months 1 Part | Employee Barbie Na Test Jr 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 101A A block 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

X 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

2F

2D

| (a)lambinipai pagawa ta amaly (a)  | انامانات        | (b) CCN or other TIN | (c) DOB (If SSN | (d) Covered   |     |     |        |                 | (e) | (e) Months of Coverage | f Covera | Эe  |      |      |                           |        |
|--|-----------------|----------------------|-----------------|---------------|-----|-----|--------|-----------------|-----|------------------------|----------|-----|------|------|---------------------------|--------|
| (a) Marrie di covered marv   | ndda(3)         |                      | not available)  | all 12 months | Jan | Feb | Mar    | Apr             | May | June                   | July     | Aug | Sept | Oct  | Nov                       | Dec    |
| 17   |                 | *****4654            | 12/12/2012      | X             |     |     |        |                 |     |                        |          |     |      |      |                           |        |
| 18   |                 |                      | 10/10/2010      |               | X   | X   | X      | X               | X   | X                      |          |     |      |      |                           |        |
| 19   |                 | ******6546           | 01/01/2010      |               |     |     |        |                 |     |                        | X        | X   | X    | X    | X                         | X      |
| 20   |                 |                      |                 |               |     |     |        |                 |     |                        |          |     |      |      |                           |        |
| 21   |                 |                      |                 |               |     |     |        |                 |     |                        |          |     |      |      |                           |        |
| 52   |                 |                      |                 |               |     |     |        |                 |     |                        |          |     |      |      |                           |        |
| For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. | k Reduction Act | Notice, see separate | instructions.   |               |     |     | Cat. N | Cat. No. 60705M | Σ   |                        |          |     |      | Form | Form <b>1095-C</b> (2016) | (2016) |

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

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|      | OMB No. 1545-2251 | 9102      |
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Employer-Provided Health Insurance Offer and Coverage

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

| Part   Employee  | yee           |                                   |             |              |  |                 | Ap  | plicable La        | Applicable Large Employer Member (Employer) | yer Memb      | ər (Employe    | er)                                       |                |
|--|---------------|-----------------------------------|-------------|--------------|--|-----------------|---|--------------------|---|---------------|----------------|---|----------------|
| 1 Name of employee   |               |                                   |             | 2 Soci       | 2 Social security number (SSN)                           | ır (SSN)        | 7 Name of employer  | loyer              |   |               | 8 Emp          | 8 Employer identification number (EIN)    | number (EIN)   |
| Charles Na Test Sr   | t Sr          |                                   |             |              | *****  | 3               | Sanjay Nine test 2  | test 2             |   |               |                | 99-4446546                                | 16             |
| 3 Street address (including apartment no.)   | uding apartme | nt no.)                           |             |              |  |                 | 9 Street address (including room or suite no.)  | s (including roon  | n or suite no.)                             |               | <b>10</b> Cont | 10 Contact telephone number               | nber           |
| 101A A block   |               |                                   |             |              |  |                 | 456 789   |                    |   |               |                | 5464646464                                | 54             |
| 4 City or town   | 5             | 5 State or province               | eol         | 6 Count      | 6 Country and ZIP or foreign postal code 11 City or town | ign postal code | 11 City or town   |                    | 12 State or province                        | ovince        | <b>13</b> Coun | 13 Country and ZIP or foreign postal code | in postal code |
| CAMBRIA  | CA            | A                                 |             | 24568        | ~  |                 | ANTHONY   |                    | FL  |               | 65465          | 10  |                |
| Part II Emplo  | yee Offer     | <b>Employee Offer of Coverage</b> | age         |              |  |                 | Plan Start Month (Enter 2-digit number): 06   | <b>Month</b> (Ente | r 2-digit num                               | ıber): 06     |                |   |                |
| Ą  | All 12 Months | Jan                               | Feb         | Mar          | Apr  | May             | June  | July               | Aug   | Sept          | Oct            | Nov                                       | Dec            |
| 14 Offer of<br>Coverage (enter<br>required code)                                   | H.            |                                   |             |              |  |                 |   |                    |   |               |                |   |                |
| 15 Employee Required Contribution (see instructions)                               |               | €.                                | €5          | €.           | €.   | ₩.              | €.  | €5                 | <del>G</del>                                | €.            | <del>v.</del>  | <del>G</del>                              | <del>€</del>   |
| 16 Section 4980H<br>Safe Harbor and<br>Other Relief (enter<br>code, if applicable) |               | 2D                                | 2F          | 2F           | 2F   | 2F              | 2F  | 2F                 | 2F  | 2F            | 2F             | 2F  | 2F             |
| Part III Covered Individuals   | ed Individ    | uals                              |             |              | -  | -               |   |                    |   |               |                |   |                |
| If Empl  | oyer provid   | ed self-insu                      | red coverag | e, check the | e box and ent  | er the inform   | If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. | ı individual e     | nrolled in cov                              | /erage, inclu | ding the emp   | loyee.                                    |                |

|  | Dec  |   |
|--|--|---|
|  | Nov  |   |
|  | Oct  |   |
|  | Sept   | [ |
| ge                                       | Aug  |   |
| of Covera                                | July   |   |
| (e) Months of Coverage                   | June   |   |
| (e)                                      | May  | ] |
|  | Apr  |   |
|  | Mar  |   |
|  | Feb  | ] |
|  | Jan  |   |
| (d) Covered                              | all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec | [ |
| (c) DOB (If SSN                          | or other IIN is not available)                                   |   |
| H 1000                                   | (a) SSIN OF OTHER LIIN   |   |
| (-)(-)(-)(-)(-)(-)(-)(-)(-)(-)(-)(-)(-)( | (a) Name of covered individual(s)                                |   |
|  |  |   |

8

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Cat. No. 60705M

Form **1095-C** (2016)

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- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your

- spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

Diesel Na Test Jr 101A A block CAMBRIA, CA, 24569 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

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

| _    |           |
|------|-----------|
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| 1005_C   |                       | Emp                               | Jover-Pr    | ovided 1                           | Employer-Provided Health Insurance Offer and Coverage | Surance                                    | Offer an  | nd Covers                                      | age                  | NON       |                | OMB No. 1545-2251                         | 545-2251       |
|--|-----------------------|-----------------------------------|-------------|------------------------------------|---|--|---|--|----------------------|-----------|----------------|---|----------------|
| Form Form Department of the Treasury   | reasury               | L<br>i                            | •           | ▶ Do not attach to y               | h to your tax re                                      | eturn. Keep fo                             | your tax return. Keep for your records.                 | s<br>S   | 0                    | CORF      |                |   | 9              |
| Internal Revenue Service   | rvice                 | ► Infor                           | mation abou | ▶ Information about Form 1095-C an | C and its sepa  | rate instructi                             | d its separate instructions is at www.irs.gov/form1095c | v.irs.gov/form                                 | 1095c                |           |                | 98  | 2              |
| Pari   Employee  | ployee                |                                   |             |                                    |   |  | Ap  | Applicable Large Employer Member (Employer)    | irge Emplo           | yer Membe | ∍r (Employ∈    | er)                                       |                |
| 1 Name of employee   | /ee                   |                                   |             | 2 Socia                            | 2 Social security number (SSN)                        | r (SSN)                                    | 7 Name of employer                                      | loyer  |                      |           | 8 Empi         | 8 Employer identification number (EIN)    | n number (EIN) |
| Diesel Na Test Jr  | st Jr                 |                                   |             |                                    | *****   |  | Sanjay Nine test 2                                      | test 2   |                      |           |                | 99-4446546                                | 46             |
| 3 Street address (including apartment no.)   | including apartn      | nent no.)                         |             |                                    |   |  | 9 Street addres.  | 9 Street address (including room or suite no.) | n or suite no.)      |           | 10 Cont        | 10 Contact telephone number               | mber           |
| 101A A block   |                       |                                   |             |                                    |   | •  | 456 789   |  |                      |           |                | 5464646464                                | -64            |
| 4 City or town   |                       | 5 State or province               | ээг         | 6 Country and                      | ry and ZIP or forei                                   | ZIP or foreign postal code 11 City or town | 11 City or town   |  | 12 State or province | vince     | <b>13</b> Coun | 13 Country and ZIP or foreign postal code | gn postal code |
| CAMBRIA  |                       | CA                                |             | 24569                              |   |  | ANTHONY   |  | FL                   |           | 65465          | 10  |                |
| Part    Em   | ployee Off $\epsilon$ | <b>Employee Offer of Coverage</b> | аде         |                                    |   |  | Plan Start  | Plan Start Month (Enter 2-digit number): 06    | r 2-digit num        | ber): 06  |                |   | Ī              |
|  | All 12 Months         | Jan                               | Feb         | Mar                                | Apr   | May  | June  | July   | Aug                  | Sept      | Oct            | Nov                                       | Dec            |
| 14 Offer of<br>Coverage (enter<br>required code)                                   | HI HI                 |                                   |             |                                    |   |  |   |  |                      |           |                |   |                |
| 15 Employee<br>Required<br>Contribution (see<br>instructions)                      | ₩                     | ↔                                 | ↔           | ↔                                  | ↔   | ↔  | ₩   | ↔  | ₩                    | \$        | \$             | \$  | \$             |
| 16 Section 4980H<br>Safe Harbor and<br>Other Relief (enter<br>code, if applicable) |                       | 2D                                | 2F          | 2F                                 | 2F  | 2F   | 2F  | 2F   | 2F                   | 2F        | 2F             | 2F  | 2F             |
| Part III Covered Individuals   | rered Indivi          | iduals                            |             |                                    |   |  |   |  |                      |           |                |   |                |

| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)  Part III Covered Individuals | red Individua                     | 2D IIs      | 2F                     | 2F          | 2F  | 2F            | 2F          | 2F         | 2F             | 2F                     | 2F           | 2F      | 2F |
|---|-----------------------------------|-------------|------------------------|-------------|---|---------------|-------------|------------|----------------|------------------------|--------------|---------|----|
| If Empl   | loyer provided                    | self-insure | ed coverage,           | , check the | If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. | je informatio | on for each | individual | enrolled in co | rerage, inclu          | ding the emp | oloyee. |    |
| fo emeN (e)   | (a) Name of covered individual(s) | (8)         | NIT setto or other TIN | other TIN   | (c) DOB (If SSN   | (d) Covered   |             |            | (e)            | (e) Months of Coverage | ərage        |         |    |
|   |                                   | 2           | 5                      |             |   |               |             |            |                |                        |              |         |    |

| (a) Name of covered individual(s)  | (a) SSN or other IIN      | or other TIN is<br>not available) | all 12 months | Jan | Feb | Mar    | Apr             | May | June | July | Aug | Sept | Oct  | Nov                | Dec    |
|--|---------------------------|-----------------------------------|---------------|-----|-----|--------|-----------------|-----|------|------|-----|------|------|--------------------|--------|
| 17   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| 18   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| 19   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| 20   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| 21   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| 22   |                           |                                   |               |     |     |        |                 |     |      |      |     |      |      |                    |        |
| For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. | ct Notice, see separate i | nstructions.                      |               |     |     | Cat. N | Cat. No. 60705M | Σ   |      |      |     |      | Form | Form 1095-C (2016) | (2016) |

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

Cat. No. 60705M

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

Evan Na Test Sr 101A A block CAMBRIA, CA, 24570 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

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

Department of the Treasury Internal Revenue Service

Part | Employee **1095-C** 

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

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

|     | OMB No. 1545-2251 | 2016      |
|-----|-------------------|-----------|
| 200 |                   | CORRECTED |

Applicable Large Employer Member (Employer) ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

|  |                  |                     |             |               |   |                | -  |                    |   |               |                |   |                |
|--|------------------|---------------------|-------------|---------------|---|----------------|--|--------------------|---|---------------|----------------|---|----------------|
| 1 Name of employee   | ,ee              |                     |             | 2 Socia       | 2 Social security number (SSN)  | (NSS)          | 7 Name of employer                             | loyer              |   |               | 8 Emp          | 8 Employer identification number (EIN)    | າ number (EIN) |
| Evan Na Test Sr  | Sr               |                     |             |               | 4009****  |                | Sanjay Nine test 2                             | test 2             |   |               |                | 99-4446546                                | 16             |
| 3 Street address (including apartment no.)   | including apartn | nent no.)           |             |               |   |                | 9 Street address (including room or suite no.) | s (including roor  | n or suite no.)                             |               | <b>10</b> Cont | 10 Contact telephone number               | nber           |
| 101A A block   |                  |                     |             |               |   | -              | 456 789  |                    |   |               |                | 5464646464                                | 64             |
| 4 City or town   |                  | 5 State or province | o           | 6 Countr      | 6 Country and ZIP or foreign postal code 11 City or town  | gn postal code | 11 City or town                                |                    | 12 State or province                        | vince         | <b>13</b> Coun | 13 Country and ZIP or foreign postal code | yn postal code |
| CAMBRIA  |                  | CA                  |             | 24570         |   |                | ANTHONY  |                    | FL  |               | 65465          | 10  |                |
| Part   Employee Offer of Coverage  | Joyee Offe       | er of Covera        | age         |               |   |                | Plan Start                                     | <b>Month</b> (Ente | Plan Start Month (Enter 2-digit number): 06 | ber): 06      |                |   |                |
|  | All 12 Months    | Jan                 | Feb         | Mar           | Apr   | May            | June   | July               | Aug   | Sept          | Oct            | Nov                                       | Dec            |
| 14 Offer of<br>Coverage (enter<br>required code)                                   | Ŧ                |                     |             |               |   |                |  |                    |   |               |                |   |                |
| 15 Employee<br>Required<br>Contribution (see<br>instructions)                      | ↔                | €                   | ↔           | ↔             | ₩   | ↔              | ↔  | ↔                  | ₩   | ↔             | \$             | ↔   | ₩              |
| 16 Section 4980H<br>Safe Harbor and<br>Other Relief (enter<br>code, if applicable) |                  | 2D                  | 2F          | 2F            | 2F  | 2F             | 2F   | 2F                 | 2F  | 2F            | 2F             | 2F  | 2F             |
| Part III Covered Individuals   | ered Indiv       | iduals              |             |               |   |                |  |                    |   |               |                |   |                |
| If En  | iplover provi    | ided self-insu      | red coverac | ae, check the | If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. | er the inform  | ation for each                                 | individual e       | nrolled in cov                              | erade. includ | ling the emp   | lovee.                                    |                |

|                                   |                      | 1                                 | (d) Covered   |     |     |     |     | <b>(e)</b> | (e) Months of Coverage | Coverag | je<br>je |      |     |     |     |
|-----------------------------------|----------------------|-----------------------------------|---------------|-----|-----|-----|-----|------------|------------------------|---------|----------|------|-----|-----|-----|
| (a) Name of covered individual(s) | (b) SSN or other IIN | or other TIN is<br>not available) | all 12 months | Jan | Feb | Mar | Apr | May        | June                   | July    | Aug      | Sept | Oct | Nov | Dec |
| 17                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |
| 18                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |
| 19                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |
| 20                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |
| 21                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |
| 22                                |                      |                                   |               |     |     |     |     |            |                        |         |          |      |     |     |     |

Form **1095-C** (2016)

Cat. No. 60705M

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

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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.
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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).
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Fasos Na Test Jr 101A A block CAMBRIA, CA, 24571 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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Department of the Treasury Internal Revenue Service 1095-C

**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 | 9102      |
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| -elf Employee  | loyee                                       |   |            |                        |            |  |             |  | Appli       | Applicable Large Employer Member (Employer | arge E          | пріоу                | er mer                 | nber (r  |              | /er)       |   |                           |          |
|--|---|---|------------|------------------------|------------|--|-------------|--|-------------|--|-----------------|----------------------|------------------------|----------|--------------|------------|---|---------------------------|----------|
| <ol> <li>Name of employee</li> </ol>   | ф   |   |            | 2                      | Social sec | 2 Social security number (SSN)           | SSN)        | 7 Name of employer                             | f employer  |  |                 |                      |                        |          | <b>8</b> Em  | ployer id  | 8 Employer identification number (EIN)    | dmun no                   | er (EIN) |
| Fasos Na Test  | t Jr  |   |            |                        |            | 9009****                                 |             | Sanjay Nine test                               | Vine tes    | st 2                                       |                 |                      |                        |          |              | 66         | 99-4446546                                | 946                       |          |
| 3 Street address (including apartment no.)   | icluding apartm                             | nent no.)   |            |                        |            |  |             | 9 Street address (including room or suite no.) | ddress (inc | sluding roc                                | m or suite      | ) no.)               |                        |          | <b>10</b> Co | ntact tele | 10 Contact telephone number               | ımber                     |          |
| 101A A block   |   |   |            |                        |            |  |             | 456 789  |             |  |                 |                      |                        |          |              | 54(        | 5464646464                                | 164                       |          |
| 4 City or town   |   | 5 State or province   | Jce        | 9                      | Country ar | 6 Country and ZIP or foreign postal code | -           | 11 City or town                                | own         |  | <b>12</b> Sta   | 12 State or province | ince                   |          | 13 Cou       | untry and  | 13 Country and ZIP or foreign postal code | ign posta                 | ll code  |
| CAMBRIA  |   | CA  |            | 24                     | 24571      |  |             | ANTHONY  | Λ           |  | F               |                      |                        |          | 65465        | Ω          |   |                           |          |
| Part    Emp  | loyee Offe                                  | <b>Employee Offer of Coverage</b>   | age        |                        |            |  |             | Plan Start Month (Enter 2-digit number):       | art Mo      | <b>nth</b> (Ent                            | er 2-dig        | lit numb             | er): 06                |          | -            |            |   |                           |          |
|  | All 12 Months                               | Jan   | Feb        | Mar                    | ar         | Apr                                      | May         | June   | n n         | July                                       | ¥               | Aug                  | Sept                   |          | Oct          | _          | Nov                                       | ۵                         | Dec      |
| 14 Offer of<br>Coverage (enter<br>required code)                                   | <u></u>                                     |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 15 Employee Required Contribution (see instructions)                               | ₩   | ₩   | ₩          | ₩                      | \$         |  | €           | €  | ₩           |  | ₩               | 0,                   | €                      | ↔        |              | ₩          |   | \$                        |          |
| 16 Section 4980H<br>Safe Harbor and<br>Other Relief (enter<br>code, if applicable) |   | 2D  | 2F         | 2F                     | LL.        | 2F                                       | 2F          | 2F   |             | 2F   | 2               | 2F                   | 2F                     |          | 2F           |            | 2F  | 2                         | 2F       |
| Part   Cove  | Covered Individuals If Employer provided se | <b>Covered Individuals</b> If the box and enter the information for each individual enrolled in coverage, including the employee. | red cover  | age, checł             | k the bo   | x and enter                              | the inform  | ation for                                      | each inc    | Jividual 6                                 | enrolled        | in cove              | rage, in               | cluding  | the em       | ployee     |   |                           |          |
|  | 1000  | (0)(0)  | 30         | F 20 40 20 14          |            | C) DOB (If SSN                           | (d) Covered | ,eq  |             |  |                 | (e)                  | (e) Months of Coverage | Coverage |              |            |   |                           |          |
| (a) Name   | (a) Ivarne oi covered maividual(s)          | ividual(s)  | 26 (a)     | (a) Solv or other line |            | or otner IIIN IS<br>not available)       |             | nths Jan                                       | Feb         | Mar  | Apr             | Мау                  | June                   | July     | Aug          | Sept       | Oct                                       | Nov                       | Dec      |
| 17   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 18   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 19   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 20   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 21   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| 23   |   |   |            |                        |            |  |             |  |             |  |                 |                      |                        |          |              |            |   |                           |          |
| For Privacy Act and Paperwork Reduction Act Notice, see separate instructions      | nd Paperwor                                 | rk Reduction  | Act Notice | , see separ            | ate inst   | ructions.                                |             |  |             | Cat. l                                     | Cat. No. 60705M | Σ                    |                        |          |              |            | Form 1                                    | Form <b>1095-C</b> (2016) | (2016)   |