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

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

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

Rodger r Fawley 560 W Kirkland Street BUTLER, PA, 16001 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

1095.C	E	plover-Pr	ovided	Employer-Provided Health Insurance Offer and Coverage	surance	Offer	and C	overa	ğe	> _] VOID		ō	OMB No. 1545-2251	15-2251
Form Department of the Treasury Internal Revenue Service	i ↓	► Do not attach to your Information about Form 1095-C and	Do not attac it Form 1095-	Do not attach to your tax return. Keep for your records. ut Form 1095-C and its separate instructions is at www.i	our tax return. Keep for your records. its separate instructions is at www.irs.gov/form1095c	r your rec	ords.	ov/form1	. 9		CORRECTED	TED		2016	9
Part Employee							Applic	able La	Applicable Large Employer Member (Employer)	oyer Me	mber (I	Employ	(er)		
1 Name of employee			2 Socia	2 Social security number (SSN)		7 Name of employer	employer					8 Em	ployer ide	8 Employer identification number (EIN)	number (
Rodger r Fawley				*****8792		AmandaB	ω						22-	22-222212	2
3 Street address (including apartment no.)	artment no.)				6,	9 Street add	dress (inclu	uding room	9 Street address (including room or suite no.)			10 Cor	ntact tele	10 Contact telephone number	nber
560 W Kirkland Street					Ω	5 Crazy Street	Street						555	5551112222	22
4 City or town	5 State or province	ince	6 Count	6 Country and ZIP or foreign postal code 11 City or town	n postal code	1 City or to	wn		12 State or province	rovince		13 Cou	ntry and Z	13 Country and ZIP or foreign postal code	n postal co
BUTLER	РА		16001		<u>IE</u>	RUSSELLVILLE	LVILLE		SC			29302	2		
Part II Employee Offer of Coverage	ffer of Cove	rage			_	Plan Sta	ırt Mon	th (Enter	Plan Start Month (Enter 2-digit number):	mber): 02	2				
All 12 Months	ths Jan	Feb	Mar	Apr	May	June		July	Aug	Sept		Oct	Z	Nov	Dec
14 Offer of Coverage (enter required code)	#	=	丰	H H	壬	=		H.	<u></u> =	=		<u></u> =		H H	1
15 Employee Required Contribution (see instructions)	₩	-	↔	₩	₩	↔	₩.		₩	↔	₩.		₩.	3,	\$ 91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A		2A	2A	2A		2D	N	2D	
Part III Covered Individuals If Employer provided self-insured coverage, check the box	ividuals ovided self-ins	ured coverag	Je, check the		and enter the information for each individual enrolled in coverage, including the employee.	ation for e	ach indi	vidual en	rolled in o	overage, ii	ncluding	the em	ployee	X	
(a) Name of covered individual(a)	individual(e)	NSS (4)	(b) SSN or other TIN	(c) DOB (If SS		g				(e) Months of Coverage	Coverage				
(a) ivalle of covered	ilidividdai(3)	Nico (a)		not available)	all 12 months	hs Jan	Feb	Mar	Apr May	June	July	Aug	Sept	Oct	Nov Dec
17															
ę															
2															

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	d coverage, check the	box and enter th	e informatio	n for e	ach indi	vidual e	enrolled	in cove	rage, ir	ıcluding	the em	nployee	X		
(a) Initial programme of comply (c)	NIC 30 NOS (4)	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	Coverage	0				
(a) Name of covered individual(s)	(a) Solv of Offier LIIV	or otner IIIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															

Form **1095-C** (2016)

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.

- 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
- soverage 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

June Lamoureux 8067 Tanglewood Street CORONA, NY, 11368 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

OMB No. 1545-2251 2016

CORRECTED

VOID

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

Employer-Provided Health Insurance Offer and Coverage

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

Internal Descent Consists	i casul y	▼ Infor	mote noitem	+ Form 1095	Cand ite cans	rate instruct	Information shout Form 1005-C and its senarate instructions is at unum irs nou/form1005c	ire gov/form1	0050				D
	al vice							10.904.101					
Fair	oloyee						App	olicable La	rge Emplo	Applicable Large Employer Member (Employer)	(Employer	r.	
1 Name of employee	99/			2 Socie	2 Social security number (SSN)	ır (SSN)	7 Name of employer	yer			8 Emplo	8 Employer identification number (EIN)	number (EIN)
June Lamoureux	reux				*****9632	2	AmandaB					22-222212	2
3 Street address (including apartment no.)	including apartn	nent no.)					9 Street address (including room or suite no.)	(including room	or suite no.)		10 Conta	10 Contact telephone number	ıber
8067 Tanglewood Street	vood Street						5 Crazy Street	₩				5551112222	22
4 City or town		5 State or province	ээг	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	vince	13 Country	13 Country and ZIP or foreign postal code	n postal code
CORONA		≻N		11368	~		RUSSELLVILLE		SC		29302		
Part Em	ployee Offe	Employee Offer of Coverage	age				Plan Start Month (Enter 2-digit number): 02	lonth (Enter	2-digit num	ber): 02			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		丰	王	=	Ŧ	=	1E	1	1E	1	1	15	1
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	rered Indiv	iduals			-								

box and enter the information for each individual enrolled (c) DOB (if SSN (d) Covered or other TN is not available) all 12 months Jan Feb Mar Apr Covered or other TN is not available) all 12 months Jan Feb Mar Apr Covered or other TN is not available) all 12 months Jan Feb Mar Apr Covered or other TN is not available) all 12 months Jan Feb Mar Apr Covered or other TN is not available)	box and enter the information for each individual enrolled in covera (c) DOB (if SSN (d) Covered or other TIN is not available) Individual enrolled in covera (e) Mon or other TIN is all 12 months Jan Feb Mar Apr May Junt available) Individual enrolled in covera (e) Mon Apr May Junt available) Individual enrolled in covera (e) Mon Apr May Junt Apr May	box and enter the information for each individual enrolled in coverage, incl. (c) DOB (if SSN (d) Covered or other TIN is norths Jan Feb Mar Apr May June Jule or other TIN is norths Jan Feb Mar Apr May June Jule Jule Jule Jule Jule Jule Jule Jul	box and enter the information for each individual enrolled in coverage, including the (e) DOB (if SSN (d) Coverage or other TIN is of the TIN	box and enter the information for each individual enrolled in coverage, including the employ (b) DOB (if SSN (d) Coverage or other TiN is all 12 months Jan Feb Mar Apr May June July Aug Sept or other TiN is all 12 months Jan Feb Mar Apr May June July Aug Sept Individual enrolled in Coverage or other TiN is all 12 months Jan Feb Mar Apr May June July Aug Sept Individual enrolled in Coverage or other TiN is all 12 months Jan Feb Mar Apr May June July Aug Sept Individual enrolled in Coverage or other Tin Individua	Coverage Coverage	Sepox and enter the information for each individual enrolled in coverage, including the employee. X
(d) Covered (d) Covered (e) Covered	the information for each individual enrolled in covera (d) Covered all 12 months Jan Feb Mar Apr May Ju	the information for each individual enrolled in coverage, incl. (d) Covered all 12 months Jan Feb Mar Apr May June Jule Jule Jule III III III III III III III III III I	the information for each individual enrolled in coverage, including the (d) Coverage all 12 months Jan Feb Mar Apr May June July Aug all 12 months of Coverage all 12 months of Cove	the information for each individual enrolled in coverage, including the employ (d) Coverage all 12 months Jan Feb Mar Apr May June July Aug Sept Sept Sept Sept Sept Sept Sept Sept		
Jan Feb Mar Apr	Jan Feb Mar Apr May Ju	In the each individual enrolled in coverage, included in the property of Columbia of Col	In the each individual enrolled in coverage, including the laborate of the l	To reach individual enrolled in coverage, including the employ		
Mar Apr	Mar Apr May Ju	Mar Apr May June Jule Mar Apr May June Jule May May	Mar Apr May June July Aug Mar Apr May June July Aug May Ju	Mar Apr May June July Aug Sept May June July Aug Sept May June July Aug May		
enrolled Apr Apr	enrolled in covera (e) Mol	Apr May June Jule Ju	Coverage, including the Apr May June July Aug May June July Aug May	Coverage		
	(e) Mol	(e) Months of Color May June Jul	May June July Aug	(e) Months of Coverage May June July Aug Sept		

Form **1095-C** (2016)

Cat. No. 60705M

5 F

AmandaB 5 Crazy Street RUSSELLVILLE, SC, 29302

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.

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.

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
- soverage 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

Jordon g Eichorn 8332 Harvard Lane SHEBOYGAN, WI, 53081 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

VOID

Employer-Provided Health Insurance Offer and Coverage

	1095-C and its separate instructions is at www.irs.gov/form1095c
	for
	Š
	8
	irs.
ş	3
٢	3
ö	3
ě	Ħ
_	a
₹	<u>.8</u>
attach to your tax return. Keep for your records.	ns
₫	엹
õ	×
8	Ξ
Ž	Š
Ξ.	.⊑
Ξ	Φ
3	Ħ
ᇴ	≌
2	ä
×	ĕ
42	Ö
┶	Ś
Ξ	Ξ
≍	፵
2	a
_	O
ਹ	ᇈ
ā	õ
뉽	2

1005_C	_	E	<u> </u>	Emplover-Provided Hea	ided He	ealth Ins	urance	Ith Insurance Offer and Coverage	d Cover	9ge	VOID		OMB No. 1545-2251	545-2251
Form Department of the Treasury	asury	ĺ		P Do I	not attach t	o your tax ret	urn. Keep fo	▶ Do not attach to your tax return. Keep for your records.	s S	0	CORRECTED	RECTED		9
Internal Revenue Service	/ice	▶ Info	rmat	ion about Fo	rm 1095-C	and its separa	ate instruction	▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	.irs.gov/form	1095c			9	
Part Employee	loyee							Ap	plicable La	irge Emplo	Applicable Large Employer Member (Employer)	۶r (Employ	er)	
1 Name of employee	Ф				2 Social se	2 Social security number (SSN)		7 Name of employer	oyer			8 Emp	8 Employer identification number (EIN)	in number (EIN)
Jordon g Eichorn	r.					9/22****		AmandaB					22-222212	112
3 Street address (including apartment no.)	cluding apartm€	ent no.)						9 Street address (including room or suite no.)	s (including roon	η or suite no.)		10 Cont	10 Contact telephone number	mber
8332 Harvard Lane	-ane						11	5 Crazy Street	iet				5551112222	222
4 City or town	5	5 State or province	ince		6 Country and	and ZIP or foreign	ροstal code	ZIP or foreign postal code 11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	ign postal code
SHEBOYGAN	>	M			53081		<u></u>	RUSSELLVILLE	TLE	SC		29302	0.1	
Part II Employee Offer of Coverage	loyee Offer	r of Cover	rage					Plan Start Month (Enter 2-digit number): 02	Month (Ente	r 2-digit num	iber): 02			
	All 12 Months	Jan		Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		Ŧ		1	1E	1	1	1E	1	Ŧ	Ŧ	Ħ	Ŧ]
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 se	Covered Individuals If Employer provided self-insured coverage, check the box	duals ded self-insu	ured	coverage, c	heck the b	ox and enter	the inform:	and enter the information for each individual enrolled in coverage, including the employee.	individual er	rolled in cov	rerage, includ	Jing the emp	lovee.	

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

		(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	f Covera	ge				
(a) Name of covered individual(s)	(b) SSN or other LIN	or other IIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Jordon g Eichorn	929*****	03-19-1994	\times												
18 Maggie Eichorn	****4789		\times												
19 Jason Eichorn	*****6439		\times												
20 Brock Eichorn	****1724		\boxtimes												
21 Lucy Eichorn	898****		\times												
22 Jordon Eichorn Jr	****3103		\boxtimes												
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	t Notice, see separate	instructions.		-	-	Cat. N	Cat. No. 60705M						Form	Form 1095-C (2016)	(2016)

Page 3 Dec Nov Oct Social security number (SSN) Sept Aug (e) Months of coverage Ju Jun Мау Apr Mar Feb Jan (c) DOB (If SSN or other (d) Covered TIN is not available) all 12 months \times (b) SSN or other TIN 0//0**** Covered Individuals — Continuation Sheet (a) Name of covered individual(s) 23 Kerrigan Eichorn Form 1095-C (2016) Name of employee Part III 24 윉 8 8 ଷ ဗ 8 ဗ္ဗ 8 27 સ

Form **1095-C** (2016)

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.
 - coverage offered to your dependently) 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).

 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

Chris t Borkowski Jr 9538 Applegate St HERNANDO, MS, 38632 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251	2016
1] CORRECTED

VOID

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 910 10 Contact telephone number 22-222212 5551112222 ₩ 8 8 S Applicable Large Employer Member (Employer) 29302 ö S Plan Start Month (Enter 2-digit number): 02 Sept 12 State or province ↔ 9 Street address (including room or suite no.) Aug ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c SC 8 July RUSSELLVILLE 7 Name of employer () 5 Crazy Street 6 Country and ZIP or foreign postal code 11 City or town AmandaB June S May 2 Social security number (SSN) ᡐ *****9116 Apr S 38632 Маг 8 Feb HERNANDO MS
Part II Employee Offer of Coverage S 5 State or province Jan Street address (including apartment no.) S 91.00 All 12 Months <u>1</u>E Part | Employee Chris t Borkowski Jr 9538 Applegate St Internal Revenue Service 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

Covered Individuals Part III

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

X

(a) for injurity in processing the control (a)	MIT 20th of other	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	f Covera	ge				
(a) Ivalie of covered individual(s)	(a) Solv of Officer Link	or other rin is 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.	t Notice, see separate i	instructions.		-		Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

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
- soverage 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

AmandaB 5 Crazy Street RUSSELLVILLE, SC, 29302

Ruthanne f Tomey 449 West Rose Street Apt 18 AMBLER, PA, 19002 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury 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
Olov	CORRECTED

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec 10 Contact telephone number 5551112222 22-222212 ₩ 8 8 S Applicable Large Employer Member (Employer) 29302 ö S Plan Start Month (Enter 2-digit number): 02 Sept 12 State or province ↔ 9 Street address (including room or suite no.) Aug SC () July RUSSELLVILLE 7 Name of employer () 5 Crazy Street 6 Country and ZIP or foreign postal code 11 City or town AmandaB June S May 2 Social security number (SSN) ᡐ *****7410 Apr S 19002 Маг () Feb AMBLER | PA | PA | Part II | Employee Offer of Coverage S 5 State or province Jan Street address (including apartment no.) 449 West Rose Street Apt 18 S 91.00 All 12 Months <u>1</u>E Part | Employee Ruthanne f Tomey 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

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.	ed coverage, check the	box and enter the	e informatio	n for ea	ch indi	vidual er	rolled	n cove	rage, in	cluding	the er	nploye	<u>اک</u> نه		
(a) Name of covered individual (c)	(A) CON OX CHO	(c) DOB (If SSN	(d) Covered					≥ (e)	(e) Months of Coverage	Coverage	m				
(a) Marine of Covered individual(s)	NILL BILL ON OCION (CI)	or other TIIN IS 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 inst	t Notice, see separate in	nstructions.		-		Cat. No	Cat. No. 60705M	_	_				Form	Form 1095-C (2016)	(2016)

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.
 - 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
- 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).

self-insured employer-sponsored coverage for one or more months of the calendar year. This

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

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

5 Crazy Street RUSSELLVILLE, SC, 29302

AmandaB

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251	2016
NOID		CORRECTED

									,					
Part Employee	ployee							ΑÞ	plicable La	arge Emple	yer Memb	Applicable Large Employer Member (Employer)	er)	
1 Name of employee	yee			2 Soc	2 Social security number (SSN)	umber (SSN)		7 Name of employer	oyer			8 Emp	8 Employer identification number (EIN	on number (EIN
Dominga j Lapp	ddı				*****4075	1075	< <	AmandaB					22-222212	212
3 Street address (including apartment no.)	(including apartm	nent no.)					5,	9 Street address (including room or suite no.)	s (including rooi	m or suite no.)		10 Cor	10 Contact telephone number	ımber
30 East Fawn Street	n Street						2	5 Crazy Street	et				5551112222	222
4 City or town	4,	5 State or province	Эсе	6 Cou	intry and ZIP or	r foreign post	tal code 1	6 Country 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	ign postal code
MOUNT HOLLY		N		09080	09		Ľ	RUSSELLVILLE	LE	SC		29302	2	
Part II Employee Offer of Coverage	ployee Offe	er of Cover	age	-			_	Plan Start Month (Enter 2-digit number): 02	Month (Ente	ər 2-digit nur	nber): 02			
	All 12 Months	Jan	Feb	Mar	Apr		May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1													
15 Employee Required Contribution (see	91.00	4	¥	U	U ,	4		U	¥	U	¥	¥	¥	¥
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	>	>	•	>)	•		.))	>	•	-	+
Part III Covered Individuals	rered Indivi	duals	- -	-	-	-			=	- -	-			
<u> </u>	It Employer provided seit-insured coverage, check the I	ded self-Insr	ıred coveraç	ge, check ti	he box and	enter the	ıntorma	box and enter the information for each individual enrolled in coverage, including the employee.	ı individual e	anrolled in co	verage, ıncı	iding the em	Sloyee.	

-	· •		lal Covered					(e)	(e) Months of Coverage	Coverac	, e	, -			
(a) Name of covered individual(s)	(b) SSN or other TIN	or other TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															

Form **1095-C** (2016)

Cat. No. 60705M

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 Employer (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

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
- soverage 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.

 14. No offer of coverage (you were NOT offered any health coverage or you were offered
- coverage that is NOT minimum essential coverage).

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

Melda e Mirabella 7568 Ohio Lane WILSON, NC, 27893 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

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

	OMB No. 1545-2251	2016
NOID		CORRECTED

Part Employee	ployee						_ 	pplicable La	Applicable Large Employer Member (Employer)	yer Membe	r (Employe	er)	
1 Name of employee	уее			2 Soc	2 Social security number (SSN)	iber (SSN)	7 Name of employer	ployer			8 Emp	8 Employer identification number (EIN)	number (EIN)
Melda e Mirabella	bella				*****5522	522	AmandaB					22-222212	12
3 Street address (including apartment no.)	(including apartm	ent no.)					9 Street addres	9 Street address (including room or suite no.)	m or suite no.)		10 Cont	10 Contact telephone number	nber
7568 Ohio Lane	ıne						5 Crazy Street	eet				5551112222	22
4 City or town	43)	5 State or province	ce	6 Country a	ntry and ZIP or fc	oreign postal cod	and ZIP or foreign postal code 11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	gn postal code
WILSON		NC		27893	3		RUSSELLVILLE	/ILLE	SC		29302	01	
Part II Employee Offer of Coverage	ployee Offe	r of Covers	age				Plan Start	Month (Ente	Plan Start Month (Enter 2-digit number): 02	lber): 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	rered Indivi	duals	_	-	_	=		-	=		=	<u>></u>	

II EITIPIOYET PTOVIDEU SEIT-ITSUTEU COVETAGE, CHECK UTE DOX ATTU ETTU III ETTU III ETTU III ETTU III COVETAGE, CHECK UTE ETTIPIOYEE.	ired coverage, crieck tire			9 0 10 10	aci = 10	Middal		3	adye, II	Cidalli	a a iii 6	IIIpioye	ָּבֶׁ יבּ		
(a) Name of covered individual(s)	(b) SSN or other TIN	or other TIN is	(d) Covered					(e)	(e) Months of Coverage	Coveraç	je.				
		not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Öct	Νον	Dec
17															
18															
19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate inst	Act Notice, see separate i	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

Cat. No. 60705M

AmandaB

5 Crazy Street RUSSELLVILLE, SC, 29302

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

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for states single federal poverty line) and minimum essential coverage offered to your spouse and contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous 1A. Minimum essential coverage providing minimum value offered to you with an employee all 12 months of the calendar year.
- 1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C. Minimum essential coverage providing minimum value offered to you and minimum essential 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.
 - You were NOT a full-time employee for any month of the calendar year but were enrolled in 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)
 - 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).
- month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one

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)

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 **Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only amount reported on line 15 may not be the amount you paid for coverage if, for example, you minimum essential coverage providing minimum value that your employer offered you. The required to contribute any amount towards the premium, this line will report a "0.00" for the Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

Department of the Treasury Internal Revenue Service 1095-C

Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251	2016
]	CORRECTED

▶ 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	
VOID		CORRECTED

Part Employee	loyee							Applic	able La	arge E	mploy	er Mer	nber (Applicable Large Employer Member (Employer)	yer)			
1 Name of employee	96			2 So	2 Social security number (SSN)	(NSS)	7 Name of employer	employer						8 Em	8 Employer identification number (EIN)	entificati	qunu uc	er (EIN)
Ivan d Ostroff					*****0102		AmandaB	В							22	22-222212	212	
3 Street address (including apartment no.)	ncluding apartr	ment no.)					9 Street address (including room or suite no.)	ddress (incl	uding roor	n or suite	no.)			10 Co	10 Contact telephone number	phone n	umber	
193 Manhattan St	n St						5 Crazy Street	Street							52	5551112222	222	
4 City or town		5 State or province	nce	9 Cor	6 Country and ZIP or foreign postal code		11 City or town	nwc		12 Star	12 State or province	ince		13 Col	13 Country and ZIP or foreign postal code	ZIP or fore	ign posta	code
OPA LOCKA		FL		33054	54		RUSSELLVILLE	LVILLE		SC				29302)2			
Part II Emp	loyee Offe	Employee Offer of Coverage	age	-			Plan Start Month (Enter 2-digit number):	art Mon	i th (Ente	er 2-dig	it numb	er): 05	0.1					
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July	Aug	b _r	Sept		Oct	_	Nov	Dec	ပ္စ
14 Offer of Coverage (enter required code)	1E																	
15 Employee Required Contribution (see instructions)	\$ 91.00 \$	\$	↔	↔	₩.	₩	₩	↔		₩.	3,	₩	↔		↔		∨	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C																	
Part III Cove	Covered Individuals If Employer provided se	iduals ided self-insu	red cover	age, check t	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	r the inform	ation for	each indi	ividual e	nrolled	in cove	erage, in	ıcluding	y the em	ployee	X		
omely (e)	(a) Name of concession for the second (c)	امارمانمان	30 (4)	NIT 10 dto 10 NOO (4)	(c) DOB (If SS		peu				(e)	(e) Months of Coverage	Coverag	Φ				
(מ) ועמווופ		ııvıdudı(s)	ó (a)	on or orier	or other IIIN IS not available)	all 12 months	ıths Jan	Feb	Mar	Apr	Мау	June	July	Aug (Sept	Oct	Nov	Dec
17 Ivan d Ostroff	Off 		*	*****0102	04-16-1998	X												
18																		
19																		
00																		

Form 1095-C (2016)

Cat. No. 60705M

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

7

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 but NOT your dependent(s).
- soverage offered to your dependent(s) and spouse.

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential

- 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
- 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

coverage that is NOT minimum essential coverage).

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

5 Crazy Street RUSSELLVILLE, SC, 29302

AmandaB

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

OMB No. 1545-2251 2016

VOID

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

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

▶ Information about Form 1095-C ar

CORRECTED	
your tax return. Keep for your records.	ıd its separate instructions is at www.irs.gov/form1095c

Part Employee	ployee						Apr	olicable La	rge Employ	Applicable Large Employer Member (Employer)	· (Employe	.	
1 Name of employee	уее			2 Social se	2 Social security number (SSN)		7 Name of employer	ıyer			8 Emplo	8 Employer identification number (EIN)	number (EIN)
Roxanna d Dacus	acus				*****9266	A	AmandaB					22-222212	12
3 Street address	3 Street address (including apartment no.)	ent no.)				6	9 Street address (including room or suite no.)	(including room	or suite no.)		10 Conta	10 Contact telephone number	mber
47 Westport Street	Street					2	5 Crazy Street	et				5551112222	22
4 City or town	\$	5 State or province	9,	6 Country a	6 Country and ZIP or foreign postal code 11 City or town	oostal code 11	1 City or town		12 State or province	vince	13 Countr	13 Country and ZIP or foreign postal code	gn postal code
NEW BRUNSWICK	SWICK NJ			08901		<u>~</u>	RUSSELLVILLE		SC		29302		
Part Employee Offer of Coverage	ployee Offer	r of Covera	ge				Plan Start Month (Enter 2-digit number): 02	lonth (Enter	2-digit num	oer): 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	\$1.00 \$ 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 se	Covered Individuals If Employer provided self-insured coverage check the box and enter the information for each individual enrolled in coverage including the employee	duals	ed coverage	check the b	ox and enter	the informat	tion for each	ne leucivicui	you in Pollor	erade includ	Ind the empl	X	

(c) DOB (if SSN (d) Covered (e) Months of Coverage	Ab Con a serie di	(c) DOB (If SSN	(d) Covered	<u>;</u>	:		5	(e)	(e) Months of Coverage	Coverag	9 9 9	5			
(a) Narrie of covered individual(s)	(a) Solv or other Lin	or otner IIIN Is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
Roxanna d Dacus	9976****	09-16-1983		X	X	X	X	X	X	X					
18															
19															
20															
21															
22															

Form **1095-C** (2016)

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.

- 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
- soverage 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

88 Ashley Drive BLACKWOOD, NJ, 08012

5 Crazy Street RUSSELLVILLE, SC, 29302

AmandaB

Maren e Fuqua

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

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

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

Part III. Covered Individuals, Lines 17-22

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

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

	OMB No. 1545-2251	8016
VOID		CORRECTED

Part Employee	ployee							Ap	plicable Lε	arge Emplc	Applicable Large Employer Member (Employer)	۶۲ (Employ	er)	
1 Name of employee	уее			8	Social se	2 Social security number (SSN)	(SSN)	7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	number (EIN)
Maren e Fuqua	na					*****5601		AmandaB					22-222212	12
3 Street address (including apartment no.)	(including apart	ment no.)						9 Street address (including room or suite no.)	s (including roor	n or suite no.)		10 Cont	10 Contact telephone number	nber
88 Ashley Drive	ive							5 Crazy Street	et				5551112222	22
4 City or town		5 State or province	vince	9	Country ar	nd ZIP or foreig	n postal code	6 Country and ZIP or foreign postal code 11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	ın postal code
BLACKWOOD		N		õ	08012			RUSSELLVILLE	ILLE	SC		29302	~	
Part II Employee Offer of Coverage	ployee Off	er of Cove	rage					Plan Start Month (Enter 2-digit number): 02	Month (Ente	er 2-digit nun	nber): 02			
	All 12 Months	s Jan	Feb	2	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 \$	\$ 0	↔	↔	• • • •	40	\$	\$	↔	↔	↔	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
Part III Covered Individuals	vered Indiv	/iduals												

Il Employer provided sell-insured coverage, check the box and enter the minormation for each movidual emolied in coverage, including the employee.	ed coverage, crieck int	e box and enter th	e Imormatic	ou lot e		Madai		NOS III	erage, ı	ricinairi	d me ei	iipioye	E		
(a) Name of covered individual(e)	NIT yedto yo NSO (d)	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	f Covera	Эе				
(a) varie of covered individual(s)	NIII IBIII IO NOO (a)	not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate instr	ct Notice, see separate	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Cory g Plant 9622 Winchester Road **EASTON, PA, 18042**

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)

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 **Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only amount reported on line 15 may not be the amount you paid for coverage if, for example, you minimum essential coverage providing minimum value that your employer offered you. The required to contribute any amount towards the premium, this line will report a "0.00" for the

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

Part III. Covered Individuals, Lines 17-22

column (b). Column (d) will be checked if the individual was covered for at least one day in every there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in will be entered in column (e) indicating the months for which these individuals were covered. If Part I), and coverage information about each individual (including any full-time employee and month of the year. For individuals who were covered for some but not all months, information SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an hat continue Part III. OMB No. 1545-2251

VOID

1095-C Department of the Treasury

5 **Employer-Provided Health Insuran**

▶ Do not attach to your tax return. Kee

	CORRECT	
ce Otter and Coverage	p for your records.	uctions is at www.irs.gov/form1095c

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec Dec 2D 1 6 10 Contact telephone number 22-222212 5551112222 S X 8 8 1 2D S Applicable Large Employer Member (Employer) 29302 oct Ŧ 2D ᡐ Plan Start Month (Enter 2-digit number): 02 Sept 1 2D 12 State or province 8 9 Street address (including room or suite no.) Aug 2D 1 SC ₩ July 2D 1 RUSSELLVILLE 7 Name of employer () 5 Crazy Street 6 Country and ZIP or foreign postal code 11 City or town AmandaB June 1 2D S ▶ Information about Form 1095-C and its separate instru 2D May 1 2 Social security number (SSN) ᡐ *****4865 1 2A Apr S 18042 2B Маг 1 S 91.00 Feb <u>1</u> EASTON PARTIL Employee Offer of Coverage S 5 State or province 91.00 Jan <u>1</u> **Covered Individuals** Street address (including apartment no.) () All 12 Months 9622 Winchester Road Part | Employee Internal Revenue Service 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) Cory g Plant 4 City or town Part III

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	d coverage, check the	box and enter the	e informatio	n for ead	ch indiv	idual e	nrolled	in cove	rage, ir	oluding	g the er	nployee	X		
(a) Initial position of comply (a)	NIT 20 NO (4)		(d) Covered					(e)	(e) Months of Coverage	Coverag	Ф				
(a) Name of covered movidual(s)	(a) Solv of officer LIIN	or otner IIIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
99															

Form 1095-C (2016)

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.

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

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

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

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

Employer-Provided Health Insurance Offer and Coverage

OMB N)
	CORRECTED

VOID

1005_C		Emp	Employer-Provided Hea	rovidec	Health	Ith Insurance Offer and Coverage	Offer ar	nd Cover	age			OMB No. 1545-2251	545-2251
Form Form Department of the Treasury	reasury	<u>.</u> !		Do not att	ach to your tax	▶ Do not attach to your tax return. Keep for your records.	for your record	15. 15.	0	CORRECTED	RECTED		9
Internal Revenue Service	rvice	► Infor	mation abou	ut Form 109	35-C and its se	▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	tions is at www	v.irs.gov/form	1095c			1	2
Part I Employee	oloyee						Ą	Applicable Large Employer Member (Employer)	arge Emplo	yer Membe	∍r (Employ	er)	
1 Name of employee	ee/			2 Sc	2 Social security number (SSN)	ber (SSN)	7 Name of employer	loyer			8 Emp	8 Employer identification number (EIN)	in number (EIN)
Lise y Lemasters Sr	ters Sr				6/12****	62.	AmandaB					22-222212	12
3 Street address (including apartment no.)	including apartme	ant no.)					9 Street addres	9 Street address (including room or suite no.)	n or suite no.)		10 Cont	10 Contact telephone number	mber
8767 Rose Avenue	/enne						5 Crazy Street	eet				5551112222	22
4 City or town	2	5 State or province	ce	9	6 Country and ZIP or fo	ZIP or foreign postal code 11 City or town	11 City or town		12 State or province	ovince	13 Coun	13 Country and ZIP or foreign postal code	ign postal code
BRANFORD	CT	-		06405	05		RUSSELLVILLE	'ILLE	SC		29302	2	
Part II Employee Offer of Coverage	oloyee Offer	r of Covera	ıge				Plan Start	Plan Start Month (Enter 2-digit number): 02	r 2-digit num	1ber): 02			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	15												
15 Employee Required Contribution (see instructions)	\$ 91.00 \$	₩	₩	↔	₩	↔	<i></i>	₩	₩	₩	↔	₩	€
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
Part III Covered Individuals	ered Indivic	luals											

,					
	If Employer provided self-insured coverage, check	d coverage, check the	e box and enter the	.=	iformation for each individual enrolled in coverage, including the employee. $ \overline{X} $
٩	(a) Name of covered individual(e)	NIT sedto vo NSS (4)	(c) DOB (If SSN	(d) Covered	(e) Months of Coverage
2					

(a) Along of conception for the state of the	INIT "Sets "S INO (4)		d) Covered					D	MOUTERIS	(e) MOULTING OF COVERAGE	Ď				
(a) Marile of covered individual(s)	NIII OUIO OUIO (a)	not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
17															
8															
19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	t Notice, see separate	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	1095-	Form 1095-C (2016)

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 Employers (for example, you left employers during the year that were 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 soverage 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

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

5 Crazy Street RUSSELLVILLE, SC, 29302

AmandaB

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

Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

	OMB No. 1545-	204
NOID		CORRECTED

MB No. 1545-2251

9

▶ 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.

8 Employer identification number (EIN) Dec 13 Country and ZIP or foreign postal code Dec Dec 2D 10 Contact telephone number $\frac{3}{2}$ 22-222212 5551112222 ₩ X ö 8 8 2A If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. Sept S Applicable Large Employer Member (Employer) 29302 oct 2A Aug (e) Months of Coverage ↔ July Plan Start Month (Enter 2-digit number): 02 Sept 2A June 12 State or province ᡐ May 9 Street address (including room or suite no.) Aug 2A Apr 8 Mar July 2A RUSSELLVILLE 7 Name of employer Feb () 5 Crazy Street 6 Country and ZIP or foreign postal code 11 City or town AmandaB June 2A Jan () (d) Covered all 12 months 2A May 2 Social security number (SSN) ᡐ (c) DOB (If SSN or other TIN is not available) 9095**** Apr 2A S 11542 (b) SSN or other TIN Маг 2A 8 Feb 2A Part II Employee Offer of Coverage S 5 State or province Jan 2A **Covered Individuals** (a) Name of covered individual(s) 3 Street address (including apartment no.) 209 Country Club Ave Apt B 8 All 12 Months Ŧ Part I Employee 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) GLEN COVE 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) King d Pier 4 City or town Part III 8 19 1 20

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

ដ

7

Cat. No. 60705M

Form 1095-C (2016)

An 5 (Rl

AmandaB 5 Crazy Street RUSSELLVILLE, SC, 29302

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.

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.

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

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

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

Arlyne d Mccolley 98 Glenridge Court WOODSIDE, NY, 11377 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury nternal 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.

ō	
VOID	CORRECTED

MB No. 1545-2251

6

8 Employer identification number (EIN) Dec 13 Country and ZIP or foreign postal code Dec Dec 1 2A 10 Contact telephone number $\frac{3}{2}$ 22-222212 5551112222 ₩ X ö <u>8</u> 1 2A If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. Sept S Applicable Large Employer Member (Employer) 29302 oct Ŧ 2A Aug (e) Months of Coverage ↔ July Plan Start Month (Enter 2-digit number): 02 Sept 2A 1 June 12 State or province ↔ May 9 Street address (including room or suite no.) Aug 2A 1 Apr ₩ Mar July 1 **2A** RUSSELLVILLE 7 Name of employer ₩ Feb 5 Crazy Street 11 City or town AmandaB June 2B 1 Jan S (d) Covered all 12 months 91.00 6 Country and ZIP or foreign postal code May <u>1</u>E 2 Social security number (SSN) S (c) DOB (If SSN or other TIN is not available) 91.00 *****7557 Apr 日 S 91.00 11377 (b) SSN or other TIN Маг 日 ₩ Feb 1 2D Part II Employee Offer of Coverage () 5 State or province Jan 2D 1 **Covered Individuals** (a) Name of covered individual(s) Street address (including apartment no.) ₩ All 12 Months Part I Employee 98 Glenridge Court Arlyne d Mccolley S 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) WOODSIDE 4 City or town Part III 8 19 1 20

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

ដ

7

Cat. No. 60705M

Form 1095-C (2016)

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 effered.

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
- Soverage 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
- 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

self-insured employer-sponsored coverage for one or more months of the calendar year. This

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

coverage that is NOT minimum essential coverage).

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

5 Crazy Street RUSSELLVILLE, SC, 29302

AmandaB

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

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

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

Part III. Covered Individuals, Lines 17-22

1095-C Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251	9102
NOID		CORRECTED

8 Employer identification number (EIN) 13 Country and ZIP or foreign postal code Dec 910 10 Contact telephone number 5551112222 22-222212 ₩ 8 8 S Applicable Large Employer Member (Employer) 29302 ö ↔ Plan Start Month (Enter 2-digit number): 02 Sept 12 State or province ↔ 9 Street address (including room or suite no.) Aug ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c SC ₩ July RUSSELLVILLE 7 Name of employer () 5 Crazy Street 6 Country and ZIP or foreign postal code 11 City or town AmandaB June () May 2 Social security number (SSN) ᡐ *****5737 Apr S 19050 Маг () Feb LANSDOWNE Part II Employee Offer of Coverage S 5 State or province Jan 3 Street address (including apartment no.) 8 258 Oak Meadow Avenue 91.00 All 12 Months <u>1</u>E -ashanda b Horiuchi Part | Employee Internal Revenue Service 1 Name of employee 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 14 Offer of
Coverage (enter
required code)
15 Employee
Required
Contribution (see
instructions) 4 City or town

	on for each individual enrolled in coverage, including the employee. $ \overline{\mathbf{X}} $	(e) Months of Coverage
	he informatio	(d) Covered
	e box and enter th	NSS (IŁ SSN
	d coverage, check the	NIT 20450 20 NOO (4)
Part III Covered Individuals	If Employer provided self-insured coverage, ch	(a) None of concept individual (a)
Part III		

(a) In the second for small (a)	NIT "Offer to NOO (4)	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	of Covera	ge				
(a) Name of Covered individual(s)	(a) Solv of other TIIN	or other TIIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	t Notice, see separate	instructions.				Cat. P	Cat. No. 60705M	Σ					Form	1095-	Form 1095-C (2016)

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 voir spouse.
 - coverage offered to your dependent(s) but NOT your spouse.

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

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

Alaine a Lemaster 858 Wentworth Lane RALEIGH, NC, 27603 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

1095-0	<u> </u>	mplove	er-Pro	Emplover-Provided Hea	lealth In	Ith Insurance Offer and Coverage	Offer	and (Cover	age		VOID			OMB No. 1545-2251	1545-225	75
Department of the Treasury Internal Revenue Service	<u></u>	nformation	► Dc	onot attach	► 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	eturn. Keep f ırate instruct	or your re ions is at u	cords. www.irs.e	gov/form	1095c] CORRECTED	ECTED		\emptyset	2016	
Part Employee								Applic	able La	Applicable Large Employer Member (Employer)	ployer	Membe	r (Emp	loyer)			
1 Name of employee				2 Social	2 Social security number (SSN)	r (SSN)	7 Name of employer	employer					80	Employer	8 Employer identification number (EIN)	ion numb	er (EIN
Alaine a Lemaster					****3448	3	AmandaB	В						2	22-222212	212	
3 Street address (including apartment no.)	artment no.)						9 Street a	ddress (inc	luding roon	9 Street address (including room or suite no.)	(;		10	Contact to	10 Contact telephone number	number	
858 Wentworth Lane							5 Crazy Street	Street						2	5551112222	222	
4 City or town	5 State or province	rovince		6 Country and	/ and ZIP or forei	ZIP or foreign postal code	11 City or town	nwc		12 State	12 State or province		13	Country ar	13 Country and ZIP or foreign postal code	eign posta	al code
RALEIGH	NC			27603			RUSSELLVILLE	LVILLE		SC			29	29302			
Part II Employee Offer of Coverage	Offer of Cov	/erage		-			Plan St	art Mor	ith (Ente	Plan Start Month (Enter 2-digit number): 02	number):	02					
All 12 Months	ths Jan		Feb	Mar	Apr	May	June		July	Aug		Sept	Oct		Nov		Dec
14 Offer of Coverage (enter required code)	#		<u> </u>	羊	丰	#	<u>+</u>		1	1		1	1		1		ш
15 Employee Required Contribution (see instructions)	↔	↔	0,	₩	↔	↔	₩	₩.	91.00 \$		91.00 \$	91.00 \$		91.00 \$	91.00 \$		91.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	28		2A	2A	2A	2A	2D										
Part III Covered Individuals	dividuals														_		
If Employer provided self-insured coverage, check the box	rovided self-i	nsured cc	overage,	check the		and enter the information for each individual enrolled in coverage, including the employee.	ation for	each ind	ividual e	nrolled in	coverag	e, includ	ing the	employe	Š Š		
(a) Name of covered individual(s)	individual(s)		(b) SSN or other TIN	other TIN	(c) DOB (IF SC		,eq				(e) Mont	(e) Months of Coverage	age				
	(2)	•			not available)	all 12 months	ıths Jan	Feb	Mar	Apr	May June	e July	Aug	Sept	Oct	Nov	Dec
!																	
17																	
∞																	
2																	

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	ed coverage, check the	box and enter the	e informatic	on for e	ach ind	ividual	enrolled	in cov	erage, i	ncludin	g the eı	nploye	<u>×</u> نو		
(a) to the state of a small (a)	MIT 100 NOO (4)	(c) DOB (If SSN	(d) Covered					(e)	(e) Months of Coverage	f Covera	je je				
(a) Name of covered municuals)	(b) Solv of other link	or otner TIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	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	instructions.				Cat. I	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)

Instructions for Recipient

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

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

Part I. Employee.

This is your social security number (SSN). For your protection, this form may show only **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 onlete 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.

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential

- You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This spouse or dependent(s), or you, your spouse, and dependent(s)
 - 1H. No offer of coverage (you were NOT offered any health coverage or you were offered code will be entered in the All 12 Months box on line 14.
- month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one

coverage that is NOT minimum essential coverage).

Maryjane h Feldmann 9109 Maple Ave CLARKSTON, MI, 48348 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)

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 **Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only amount reported on line 15 may not be the amount you paid for coverage if, for example, you minimum essential coverage providing minimum value that your employer offered you. The required to contribute any amount towards the premium, this line will report a "0.00" for the Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

Form **1095**-Department of the Tre Internal Revenue Servenue Part | Empl

, C

	OME	
Olov		CORRECTED

1095-0	Ç	Emp	Employer-Provided Hea	ovided	Health In:	surance	Offer ar	alth Insurance Offer and Coverage	age] [!	OMB No. 1545-2251	45-2251
Department of the Treasury	easury	•	•	Do not attac	▶ Do not attach to your tax return. Keep for your records.	turn. Keep f	or your recorc	S)	CORRECTED	RECTED		<u> </u>
Internal Revenue Service	rvice	► Infor	► Information about Form 1095-C an	it Form 1095-	C and its sepa	rate instruct	ions is at www	Id its separate instructions is at www.irs.gov/form1095c	1095c			9	2
Part Employee	loyee						ΑĶ	Applicable Large Employer Member (Employer)	ırge Emplo	yer Membe	er (Employ	er)	
1 Name of employee	ee			2 Socia	2 Social security number (SSN)	(NSS)	7 Name of employer	oloyer			8 Emp	8 Employer identification number (EIN)	number (EIN)
Maryjane h Feldmann	sldmann!				*****6742		AmandaB					22-222212	12
3 Street address (including apartment no.)	ncluding apart	ment no.)					9 Street addres	9 Street address (including room or suite no.)	or suite no.)		10 Con	10 Contact telephone number	nber
9109 Maple Ave	ve						5 Crazy Street	eet				5551112222	22
4 City or town		5 State or province	a)L	6 Country and	ry and ZIP or foreig	yn postal code	ZIP or foreign postal code 11 City or town		12 State or province	vince	13 Cour	13 Country and ZIP or foreign postal code	in postal code
CLARKSTON		Ξ		48348			RUSSELLVILLE	ILLE	SC		29302	2	
Part Employee Offer of Coverage	oloyee Off	fer of Covera	age				Plan Start	Plan Start Month (Enter 2-digit number): 02	r 2-digit num	ber): 02			
	All 12 Months	s 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 \$	\$ ⊙	₩	₩.	₩	↔	₩	↔	₩	\$	\$	€9	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
Parall Covered Individuals	ered Indiv	riduals											

X If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of Coverage (c) DOB (If SSN (d) Covered Cov Part III

(a) Charles of Carolina in the Carolina (a)	INIT TO THE TANK	TAIL THE STATE OF						2							
(a) Name of covered manda(s)	Solv of other lin	or other TIN IS not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Ang	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	instructions.				Cat. N	Cat. No. 60705M	>					Form	1095-	Form 1095-C (2016)

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

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 effected.

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

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

 1H. No offer of coverage (you were NOT offered any health coverage or you were offered
- coverage that is NOT minimum essential coverage).

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

Ernie n Lamoureux 8067 Tanglewood Street CORONA, NY, 11368 that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251	2016
]	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.

Falci	oloyee						App	olicable La	rge Emplo	Applicable Large Employer Member (Employer)	(Employer		
1 Name of employee	99,			2 Social	2 Social security number (SSN)	(NSS)	7 Name of employer	yer			8 Employ	8 Employer identification number (EIN)	umber (EIN)
Ernie n Lamoureux	ureux				*****1854		AmandaB					22-222212	7
3 Street address (including apartment no.)	including apartm	nent no.)					9 Street address (including room or suite no.)	(including room	or suite no.)		10 Contac	10 Contact telephone number	ber
8067 Tanglewood Street	ood Street						5 Crazy Street	it.				5551112222	2
4 City or town	4,	5 State or province	J.Ce	6 Countr	6 Country and ZIP or foreign postal code 11 City or town	yn postal code	11 City or town		12 State or province	wince	13 Country	13 Country and ZIP or foreign postal code	postal code
CORONA		Ν		11368			RUSSELLVILLE		SC		29302		
Part II Employee Offer of Coverage	oloyee Offe	er of Cover	age				Plan Start Month (Enter 2-digit number): 02	Tonth (Enter	· 2-digit num	ber): 02			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		Ŧ	Ŧ	±	丰	푸	1	1	1E	1E	1	<u>1</u>	
15 Employee Required Contribution (see instructions)	€9	s	ഗ	₩	€9	₩	\$ 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)		2B	2B	. 5C	. 5C	. 5C	. 5C		. 5C	. 5C	2C	5C	2C
Part III Cov	Covered Individuals	duals							:			>	

X If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of Coverage (c) DOB (If SSN (d) Covered (b) SSN or other TIN (a) Name of covered individual(s)

(a) Name of covered individual(s)	(b) SSN or other IIN	or other TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Ernie n Lamoureux	****1854	08-06-1991			X	X	X	X	X	X	X	X	X	X	\times
18 June Lamoureux	7896****					X	X	X	X	X	X	X	X	X	$ $ \times
19															
20															
21															
22															
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	st Notice, see separate	instructions.				Cat. N	Cat. No. 60705M	Σ					Form	Form 1095-C (2016)	(2016)