Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

LIONEL LENOIR Fully Insured
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LIONEL LENOIR Fully Insured	*****0988

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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COLBY PERRY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
COLBY PERRY	*****9558

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

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PRASHANTH PITTAL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PRASHANTH PITTAL	*****8745

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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

ERIC LINDEBLAD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ERIC LINDEBLAD	*****3423

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	ERIC LINDEBLAD	*****3423		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

VICTOR TEJEDA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VICTOR TEJEDA	*****2999

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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)

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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JANINA WRIGHT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JANINA WRIGHT	*****8732

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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CHRISTOPHER BAILEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTOPHER BAILEY	*****3490

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

VAUGHN BARKHURST
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VAUGHN BARKHURST	*****7395

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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JEANNIE HII
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEANNIE HII	*****7731

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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DARIN TAKAKI
1 Main St
GREER, RI, 12351

RMS
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AJO, AZ, 23423

600117

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Department of the Treasury
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DARIN TAKAKI	*****1988

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

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RMS	23-4232222

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sadfasdf ADFA	2342342342

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

DOUGLAS LEBLANC
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DOUGLAS LEBLANC	*****7801

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

MATTHEW ANDERSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MATTHEW ANDERSON	*****4027

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2B

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	MATTHEW ANDERSON	*****4027		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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JASON ZERO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JASON ZERO	*****8567

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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TRICIA ROEHRENBECK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TRICIA ROEHRENBECK	*****0266

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ROBERT CASHMAN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ROBERT CASHMAN	*****4833

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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WILL REAGAN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILL REAGAN	*****3490

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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ADAM SCOTT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ADAM SCOTT	*****5595

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

Part III. Covered Individuals, Lines 17-22

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

SU KIM
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SU KIM	*****8029

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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BRUCE SHAW
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRUCE SHAW	*****6856

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

JESSE GRAHAM
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESSE GRAHAM	*****0986

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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TAYLOR FORBES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TAYLOR FORBES	*****1844

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

CLINT LUDER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CLINT LUDER	*****0826

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

JEFFREY EVANS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEFFREY EVANS	*****0110

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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MARK TOMASSI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARK TOMASSI	*****1216

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

MATTHEW AGORIIWE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MATTHEW AGORIIWE	*****8225

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

MARTI JOHNSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARTI JOHNSON	*****0993

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

BARRY KLASSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BARRY KLASSON	*****8817

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	BARRY KLASSON	*****8817		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Instructions for Recipient

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Part I. Employee.

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
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Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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RAYMOND DAVIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RAYMOND DAVIS	*****3309

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	RAYMOND DAVIS	*****3309		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

BENNY GARDUNO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BENNY GARDUNO	*****8090

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

MICHAEL MELTON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL MELTON	*****5911

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

JESUS GAMA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESUS GAMA	*****1657

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

EDGARDO SANTIAGOJr
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
EDGARDO SANTIAGOJr	*****8781

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JERRY LEE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JERRY LEE	*****9182

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

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Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
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Part II. Employer Offer and Coverage, Lines 14-16.

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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Part III. Covered Individuals, Lines 17-22

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

JOSEPH LIEBSCH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSEPH LIEBSCH	*****1232

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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DAVON WHITE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVON WHITE	*****7634

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ALEXIS GUILLERMO
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEXIS GUILLERMO	*****8501

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RICHARDSON LOUISSAINT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RICHARDSON LOUISSAINT	*****7665

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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DAVID KLANG
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID KLANG	*****2862

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

DONNA BREWER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DONNA BREWER	*****9687

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DONNA BREWER	*****9687		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

MICHAEL HARDY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL HARDY	*****8337

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

GOPIKRISHNA PODILI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GOPIKRISHNA PODILI	*****1525

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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DANIEL JONES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DANIEL JONES	*****1034

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

LIANA VO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LIANA VO	*****1819

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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BRENDAN SHUMBERGER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRENDAN SHUMBERGER	*****0402

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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BRYAN SMETHERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRYAN SMETHERS	*****2055

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

WILLIE RICHARDSONJr
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIE RICHARDSONJr	*****1504

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

CARLOS VERAS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CARLOS VERAS	*****5392

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

KEITH SARGENT
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEITH SARGENT	*****5455

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ALNISA BURWELL
1 Main St
GREER, RI, 12351

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600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALNISA BURWELL	*****5836

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ANDREW MILLER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREW MILLER	*****5679

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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STUART OSTERWEIL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STUART OSTERWEIL	*****4122

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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CLAY OELZEN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CLAY OELZEN	*****4107

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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17	CLAY OELZEN	*****4107		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

STEVEN KRAKOWER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STEVEN KRAKOWER	*****6612

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

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

AARON COLON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AARON COLON	*****1586

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

DELVIN SMITH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DELVIN SMITH	*****1529

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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RMS
sadfasdf ADFA
AJO, AZ, 23423

JOSE ALOMIA
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSE ALOMIA	*****3495

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2B	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

RAMESH ARREPU
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RAMESH ARREPU	*****3663

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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DAVID ARNEMANN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID ARNEMANN	*****2286

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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17	DAVID ARNEMANN	*****2286		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

Form **1095-C** (2016)

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TRINA CARSTENS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TRINA CARSTENS	*****9087

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

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RMS	23-4232222

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

AINKA BLACKMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AINKA BLACKMAN	*****1166

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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Part III. Covered Individuals, Lines 17-22

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

JEMELL WHITE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEMELL WHITE	*****1565

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2D	2D	2D	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

CHRIS LORSAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRIS LORSAN	*****5960

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	CHRIS LORSAN	*****5960		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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SEAN CONRAD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SEAN CONRAD	*****0511

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARGARET GUSSE
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARGARET GUSSE	*****6756

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JUN CHEN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUN CHEN	*****5948

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JOSE DELGADO
1 Main St
GREER, RI, 12351

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSE DELGADO	*****5818

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

JAYONINA KING
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAYONNA KING	*****1536

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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ALEKSANDR VASILYEV
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEKSANDR VASILYEV	*****8296

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

CHARLES MILLS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHARLES MILLS	*****0440

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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JUSTIN ROSADO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUSTIN ROSADO	*****1987

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

SHELLEY STEPHENS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SHELLEY STEPHENS	*****0485

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ELIZABETH AMES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ELIZABETH AMES	*****0492

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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POORNIMA JAYAPALAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
POORNIMA JAYAPALAN	*****3065

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

BRIAN GANTT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRIAN GANTT	*****4527

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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

ROBERT HECKMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ROBERT HECKMAN	*****7464

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JASON BARKHURST
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JASON BARKHURST	*****3546

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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GREER, RI, 12351

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KERRIANN ROOMES	*****2386

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

SCOTT STEELE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SCOTT STEELE	*****4167

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

UTSAV BHARDWAJ
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
UTSAV BHARDWAJ	*****9545

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Applicable Large Employer Member (Employer)

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARLA STEWARD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARLA STEWARD	*****4519

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ELIZABETH TRIMBLE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ELIZABETH TRIMBLE	*****0616

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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WILLIAM ANDERSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM ANDERSON	*****7458

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

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PETERSON PHE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PETERSON PHE	*****0550

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
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	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 17-22

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

JOHN CARUTHERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN CARUTHERS	*****1142

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

BRITTANY PRESSEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRITTANY PRESSEY	*****9247

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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TIFFANY PRINGLE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TIFFANY PRINGLE	*****3196

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2B	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Applicable Large Employer Member (Employer)

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KIMGENE NGUYEN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KIMGENE NGUYEN	*****5147

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

ROBBIE WEISS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ROBBIE WEISS	*****2915

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

RYAN ESTOK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RYAN ESTOK	*****0926

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

Part III. Covered Individuals, Lines 17-22

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

WANDA BELL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WANDA BELL	*****4744

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DAVID PIVARAL
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID PIVARAL	*****2776

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DAVID PIVARAL	*****2776		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JEFFREY RUTHERFORD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEFFREY RUTHERFORD	*****3181

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

LABREDA CONNER
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LABREDA CONNER	*****7758

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

ERIC SPAGNOLI
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ERIC SPAGNOLI	*****4524

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

MEGAN PRESTON
1 Main St
GREER, RI, 12351

RMS
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AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MEGAN PRESTON	*****3002

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

GOKHAN KARAKUS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GOKHAN KARAKUS	*****6806

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JUSTIN SISKEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUSTIN SISKEY	*****8155

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

Form **1095-C** (2016)

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

DANECIA HAMPTON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DANECIA HAMPTON	*****5938

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LUIS MERCED
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LUIS MERCED	*****8603

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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Part III. Covered Individuals, Lines 17-22

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

MARIA JAVIER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARIA JAVIER	*****0218

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Applicable Large Employer Member (Employer)

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PETER SOKOLIK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PETER SOKOLIK	*****1748

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

TERRY CURTIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TERRY CURTIS	*****3844

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ARTEM MASLYUK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ARTEM MASLYUK	*****9935

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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DEWAINE COBB
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DEWAINE COBB	*****2969

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

FERNANDO GOMEZEVELSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
FERNANDO GOMEZEVELSON	*****0541

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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Part III. Covered Individuals, Lines 17-22

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

CHABLIS BRADY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHABLIS BRADY	*****1030

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

DANIEL KIM
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DANIEL KIM	*****4817

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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ZHIEN LI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ZHIEN LI	*****8911

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

LISA LONGCHAMPS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LISA LONGCHAMPS	*****5458

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	LISA LONGCHAMPS	*****5458		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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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
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

AARON ELDRIDGE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AARON ELDRIDGE	*****4524

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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DAVID MALLORY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID MALLORY	*****8888

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

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

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

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

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

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

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

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

Part III. Covered Individuals, Lines 17-22

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

JOSE LINARES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSE LINARES	*****1576

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JOSE LINARES	*****1576		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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FRANCIS HESKETH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
FRANCIS HESKETH	*****5261

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	FRANCIS HESKETH	*****5261		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

REBECCA TAYLOR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
REBECCA TAYLOR	*****0085

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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MAYRA KRAUSE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MAYRA KRAUSE	*****2007

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

SIMONE GAYLE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SIMONE GAYLE	*****9009

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

SRINIVAS TATAPUDI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SRINIVAS TATAPUDI	*****9855

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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TIARA MASTERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TIARA MASTERS	*****1031

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

DENISE GOMER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DENISE GOMER	*****9095

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DENISE GOMER	*****9095		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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DIANA BITLER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DIANA BITLER	*****3717

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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RMS
sadfasdf ADFA
AJO, AZ, 23423

JOHN GALAZIN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN GALAZIN	*****4436

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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

Part III. Covered Individuals, Lines 17-22

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

ANGELEC GLOVER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANGELEC GLOVER	*****3708

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

JOSHUA KAPLAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSHUA KAPLAN	*****5794

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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OTTO DUNN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
OTTO DUNN	*****8536

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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DATIKKA WRIGHT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DATIKKA WRIGHT	*****7924

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ALICE DOTSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALICE DOTSON	*****0612

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

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

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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DESIREE TURNER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DESIREE TURNER	*****6476

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

RMS
sadfasdf ADFA
AJO, AZ, 23423

DONNIE JONES
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DONNIE JONES	*****7204

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ALEKSANDR SEDLIN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEKSANDR SEDLIN	*****9465

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ALDEN WEGE
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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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*

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☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALDEN WEGE	*****6109

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

JESSICA BALL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESSICA BALL	*****3963

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JESSICA BALL	*****3963		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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

Part I. Employee.

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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.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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Part III. Covered Individuals, Lines 17-22

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

BRANDON MEDEIROS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRANDON MEDEIROS	*****8157

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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 offered.

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

ASHTON HOBELMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ASHTON HOBELMAN	*****7509

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

PAUL APONTE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PAUL APONTE	*****3058

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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DAVID MAQUILON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID MAQUILON	*****7907

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JEFF KNOX
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEFF KNOX	*****0089

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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BRIAN LUKE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRIAN LUKE	*****6120

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

COLLIN HELLUM
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
COLLIN HELLUM	*****5827

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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SHELBY MILLER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SHELBY MILLER	*****3358

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ERIC SELDIN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ERIC SELDIN	*****2545

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

STEPHEN HOWARD
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STEPHEN HOWARD	*****6014

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

GILBERT VALENZUELA
1 Main St
GREER, RI, 12351

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GILBERT VALENZUELA	*****0945

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ROGER COOK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ROGER COOK	*****3583

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DANIEL CRAWFORD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DANIEL CRAWFORD	*****2091

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARK CHRISTOFFERSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARK CHRISTOFFERSON	*****0551

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	MARK CHRISTOFFERSON	*****0551		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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sadfasdf ADFA
AJO, AZ, 23423

ANGELA BRANDT
1 Main St
GREER, RI, 12351

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANGELA BRANDT	*****4153

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

ASHLEY DIAS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ASHLEY DIAS	*****3799

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	ASHLEY DIAS	*****3799		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18	KAYDENCE DIAS	*****5549		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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AJO, AZ, 23423

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1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ENRIQUE POSSECOSTAS	*****9902

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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AJO, AZ, 23423

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1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CRAIG WELSHANS	*****6533

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DOMINIC OTTAVIANO
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DOMINIC OTTAVIANO	*****7834

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ANDREA HAVELIN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREA HAVELIN	*****7662

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

KARMIESHA ALLEN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KARMIESHA ALLEN	*****3974

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KELLAN LENO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KELLAN LENO	*****1625

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MICHAEL POTHIER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL POTHIER	*****2804

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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STEVEN PAGE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STEVEN PAGE	*****5385

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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JAMES BABALOLA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMES BABALOLA	*****5214

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

Part II Employee Offer of Coverage

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DAVID WOODFORD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID WOODFORD	*****4173

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DAVID WOODFORD	*****4173		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LUISA ROSARIO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LUISA ROSARIO	*****4575

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

VENUS SIMS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VENUS SIMS	*****2337

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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RMS
sadfasdf ADFA
AJO, AZ, 23423

BHANU VOOCHA
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BHANU VOOCHA	*****3877

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SUCHARITHA KOMATI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SUCHARITHA KOMATI	*****7199

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DAVID DEROHAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID DEROHAN	*****1709

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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NAZIR NISAR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NAZIR NISAR	*****0518

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JEFFREY BERGER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEFFREY BERGER	*****3375

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JEFFREY BERGER	*****3375		☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JACKY LIN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JACKY LIN	*****3638

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DAVID EUBANK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID EUBANK	*****0624

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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MATTHEW STEINHOUR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MATTHEW STEINHOUR	*****4660

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

HERNAN FLORES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
HERNAN FLORES	*****6533

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JAMES LEE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMES LEE	*****2752

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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JOSEPH HULGAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSEPH HULGAN	*****3196

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

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	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RUPAK BARUA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RUPAK BARUA	*****5728

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	RUPAK BARUA	*****5728		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18	JAKIA CHOUDHURY	*****7614		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

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MICHAEL CRAWFORD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL CRAWFORD	*****8778

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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Part I. Employee.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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IMRAN BOKHARI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
IMRAN BOKHARI	*****7824

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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RMS
sadfasdf ADFA
AJO, AZ, 23423

JOHN DAVID
1 Main St
GREER, RI, 12351

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600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN DAVID	*****4777

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

HUNG TRAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
HUNG TRAN	*****7195

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

CHRISTIANE PEREIRA
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTIANE PEREIRA	*****4870

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

HENOK TEKLE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
HENOK TEKLE	*****4131

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	HENOK TEKLE	*****4131		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SEAN HATHAWAY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SEAN HATHAWAY	*****6739

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

JEREMY UZZLE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEREMY UZZLE	*****0647

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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HOMER NAVOTAS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
HOMER NAVOTAS	*****0868

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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GREER, RI, 12351

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2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOJO RAPPAI	*****8321

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARGARET HUDSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARGARET HUDSON	*****4395

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GAIL ELLS
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GAIL ELLS	*****5699

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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AJO, AZ, 23423

JEROEN DERYCK
1 Main St
GREER, RI, 12351

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Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JEROEN DERYCK	*****7771

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
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Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JOHN COPPOLA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN COPPOLA	*****4867

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

NAOMI RICHARDSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NAOMI RICHARDSON	*****4794

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JAMES BLUNDELL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMES BLUNDELL	*****0172

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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JIGAR PATEL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JIGAR PATEL	*****3858

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JUDY PARETI
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUDY PARETI	*****5815

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JUDY PARETI	*****5815		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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.

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Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

OLUWAKEMI OLAIBIKUNLE
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
OLUWAKEMI OLAIBIKUNLE	*****2631

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

ALEKSANDR BOGOMOLOV
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEKSANDR BOGOMOLOV	*****8040

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RICHARD PETERSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RICHARD PETERSON	*****0949

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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CAROL MCGUIGAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CAROL MCGUIGAN	*****5128

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MONICA BUTOLIA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MONICA BUTOLIA	*****5100

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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MAGAN SCOTT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MAGAN SCOTT	*****7550

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DENNIS SMALLWOOD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DENNIS SMALLWOOD	*****0821

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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DAVID HOLLIDAY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID HOLLIDAY	*****1565

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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KIRK REID
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KIRK REID	*****9612

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JUAN FRANCOORTIZ
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUAN FRANCOORTIZ	*****1319

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

CASSANDRA SIFFORD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CASSANDRA SIFFORD	*****0812

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JUSTIN CASSELMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUSTIN CASSELMAN	*****0426

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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CODY MHOON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CODY MHOON	*****5770

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	CODY MHOON	*****5770		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KENNETH KING
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KENNETH KING	*****2716

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

TRINE MICKELSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TRINE MICKELSON	*****3870

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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BARBARA IACHELLO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BARBARA IACHELLO	*****0869

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JASON ROBERTSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JASON ROBERTSON	*****2182

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

APRIL FINLEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
APRIL FINLEY	*****3334

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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TIMOTHY MASON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TIMOTHY MASON	*****0037

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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WELDON YOUNG
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WELDON YOUNG	*****2799

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ISIDRO PARRA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ISIDRO PARRA	*****4278

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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 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.

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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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GREGORY RENKEN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GREGORY RENKEN	*****8604

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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GERALD WILLIAMS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GERALD WILLIAMS	*****1732

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
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sadfasdf ADFA	2342342342

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ZULMA TSAVDAR
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ZULMA TSAVDAR	*****8801

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JACK TELFORD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JACK TELFORD	*****9314

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KATRINA TODDKRASEN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KATRINA TODDKRASEN	*****3044

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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Form **1095-C**
Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AMOL MORE	*****5076

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LAURA GOLDSTONE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LAURA GOLDSTONE	*****2900

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JENNIFER LECOINTE
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JENNIFER LECOINTE	*****5530

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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17	JENNIFER LECOINTE	*****5530		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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HECTOR ROMERO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
HECTOR ROMERO	*****8747

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JASON VALENTINEWILEY
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JASON VALENTINEWILEY	*****1101

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JASON VALENTINEWILEY	*****1101		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

DARRYL BROOKS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DARRYL BROOKS	*****1223

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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OPHER BANARIE
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
OPHER BANARIE	*****9427

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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AJO, AZ, 23423

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GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LAIQUE AHMAD	*****3389

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

THOMAS FILLEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
THOMAS FILLEY	*****8589

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ALAN BURNETT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALAN BURNETT	*****4715

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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PETER KERNER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PETER KERNER	*****0620

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
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11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	PETER KERNER	*****0620		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MICHAEL LONCARIC
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL LONCARIC	*****0476

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GERALD NAPLES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GERALD NAPLES	*****4699

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

BASKAR WALLAJABAD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BASKAR WALLAJABAD	*****0335

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JUANCARLOS RENTERIA
1 Main St
GREER, RI, 12351

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUANCARLOS RENTERIA	*****8426

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JAMES LATZKE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMES LATZKE	*****3423

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM FITZPATRICK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM FITZPATRICK	*****7305

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

ANISA WALTERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANISA WALTERS	*****0735

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JULIA CAGNEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JULIA CAGNEY	*****6771

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

SUDHIR JARAJAPU
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SUDHIR JARAJAPU	*****3378

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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GARY OPERHALL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GARY OPERHALL	*****4984

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

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RMS	23-4232222

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	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

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	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DOUGLAS DREXLER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DOUGLAS DREXLER	*****0627

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DOUGLAS DREXLER	*****0627		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18	DAWN DREXLER	*****3264		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
19	BRANDON DREXLER	*****5220		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
20	CALEB DREXLER	*****8148		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
21	ETHAN DREXLER	*****2700		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LARRY ORMAND
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LARRY ORMAND	*****4439

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
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Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JESSE NEWSHAM
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESSE NEWSHAM	*****2178

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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DIANA NAVARRETO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DIANA NAVARRETO	*****7015

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ALYSSA GILLETT
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALYSSA GILLETT	*****2905

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

PETER McFARLAND
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PETER McFARLAND	*****4470

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ANDREA DAVIDSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREA DAVIDSON	*****2769

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SONALI KHARE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SONALI KHARE	*****3492

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

CHARLES MINCHEW
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHARLES MINCHEW	*****8499

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

TRAVIS LAGINESS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TRAVIS LAGINESS	*****5892

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MICHAEL HENNIG
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL HENNIG	*****7554

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MAHENDER KUNTA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MAHENDER KUNTA	*****1257

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

CHARLES SAWYER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHARLES SAWYER	*****1026

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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KEITH SMITH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEITH SMITH	*****8578

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

CATHERINE LANE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CATHERINE LANE	*****6046

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

OLLIE SMITH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
OLLIE SMITH	*****1745

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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
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Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LASHONDA HUGGINS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LASHONDA HUGGINS	*****9052

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
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Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SCOTT SCHUMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SCOTT SCHUMAN	*****6760

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	SCOTT SCHUMAN	*****6760		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

FRANCISCO BEJAR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
FRANCISCO BEJAR	*****7460

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	FRANCISCO BEJAR	*****7460		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ERIC WENOKOR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ERIC WENOKOR	*****7409

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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PAUL BROWN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PAUL BROWN	*****7868

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LINUS LINN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LINUS LINN	*****9466

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

NATHAN MATHIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NATHAN MATHIS	*****6217

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	NATHAN MATHIS	*****6217		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SHERRI CRUMBACHER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SHERRI CRUMBACHER	*****6084

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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SETH BEAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SETH BEAN	*****7050

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RICHARD FERRI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RICHARD FERRI	*****4574

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JOSEPHINE ONDRUSEK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOSEPHINE ONDRUSEK	*****6975

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RANDARUS MARTIN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RANDARUS MARTIN	*****9712

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MICHAEL FRIEDMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MICHAEL FRIEDMAN	*****5205

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RONALD ROBY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RONALD ROBY	*****0327

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SAHIL ARORA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SAHIL ARORA	*****0770

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

CHARLES WALLACEJr
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHARLES WALLACEJr	*****9744

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DAVID REIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID REIS	*****6611

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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KATRINA WILLIAMS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KATRINA WILLIAMS	*****1457

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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RMS
sadfasdf ADFA
AJO, AZ, 23423

EDMOND JONESJr
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
EDMOND JONESJr	*****0765

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

SUNDARA NARASIMHAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SUNDARA NARASIMHAN	*****8436

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM SENIZAIZ
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM SENIZAIZ	*****1052

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

NATHANIEL RICHARDSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NATHANIEL RICHARDSON	*****7835

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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JIMMY CHEUNG
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JIMMY CHEUNG	*****3646

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JIMMY CHEUNG	*****3646		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

NICHOLAS SIKIRICA
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NICHOLAS SIKIRICA	*****2144

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$ 49.50	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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
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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

RONALD HUDSPETH
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RONALD HUDSPETH	*****4253

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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sadfasdf ADFA
AJO, AZ, 23423

PRASHANTH KARANAM
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PRASHANTH KARANAM	*****1695

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KEVIN COLLINS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEVIN COLLINS	*****7583

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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JHAN CACERES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JHAN CACERES	*****5788

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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CATHERINE MACHO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CATHERINE MACHO	*****8732

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2B	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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CHRISTOPHER WOODWARD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTOPHER WOODWARD	*****9276

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM DEANGELO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM DEANGELO	*****6406

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MATTHEW ROBINSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MATTHEW ROBINSON	*****8604

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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KURT SOMMERHAUSER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KURT SOMMERHAUSER	*****3247

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

PATRICK SHAW
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PATRICK SHAW	*****5834

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

AVINASH CHIDDARWAR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AVINASH CHIDDARWAR	*****5657

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MASON SHAW
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MASON SHAW	*****7351

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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ADRIAN CROWELL
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ADRIAN CROWELL	*****8758

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

BRIAN MOSES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRIAN MOSES	*****8770

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

JOHN MILANO
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN MILANO	*****2638

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2G	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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DAVID ALBARRAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID ALBARRAN	*****2737

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JYOTHI DHANAPAL
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JYOTHI DHANAPAL	*****6527

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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sadfasdf ADFA
AJO, AZ, 23423

VENKATA PASUPULETI
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VENKATA PASUPULETI	*****4354

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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ZINA KLANG
1 Main St
GREER, RI, 12351

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sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ZINA KLANG	*****2105

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2A	2A	2A	2A	2A	2A

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17	ZINA KLANG	*****2105		☐	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GLENN HAYES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GLENN HAYES	*****6891

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DONNA POFF
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DONNA POFF	*****8263

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

BRIAN SCHLENKER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRIAN SCHLENKER	*****2827

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

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Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

LEONARDO VO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LEONARDO VO	*****2050

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RUBENS INABA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RUBENS INABA	*****9027

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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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).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JUSTIN MILETTE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUSTIN MILETTE	*****6661

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JUSTIN MILETTE	*****6661		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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 offered.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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TRAVIS KMIECIAK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
TRAVIS KMIECIAK	*****9406

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

AUTEAH FARAG
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
AUTEAH FARAG	*****7826

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM HALL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM HALL	*****7504

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 0.00	$ 0.00	$ 0.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	WILLIAM HALL	*****7504		☐	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

PATILLA MITCHELL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PATILLA MITCHELL	*****0017

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DARNELL BROWN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DARNELL BROWN	*****6312

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ANDREW MACKEY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREW MACKEY	*****6176

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JOHNPAUL BENEDICTO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHNPAUL BENEDICTO	*****7304

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

NATOSHIA LEWIS
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
NATOSHIA LEWIS	*****7606

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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Cat. No. 60705M

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KEVIN JOHNSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEVIN JOHNSON	*****8482

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

LAURIE EISENMANN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
LAURIE EISENMANN	*****0794

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

VICTOR MERCED
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VICTOR MERCED	*****9494

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

CHARNKIAT SUKPANICHNANT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHARNKIAT SUKPANICHNANT	*****7169

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

RAJAGOPAL PILLAI
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RAJAGOPAL PILLAI	*****2240

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GAR MAGNER
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GAR MAGNER	*****1151

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	GAR MAGNER	*****1151		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WENSEAN PAN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WENSEAN PAN	*****9059

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARKUS RAWSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARKUS RAWSON	*****3765

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

RYAN WILSON
1 Main St
GREER, RI, 12351

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sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RYAN WILSON	*****2311

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DARRYL VAUGHN
1 Main St
GREER, RI, 12351

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AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DARRYL VAUGHN	*****4483

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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sadfasdf ADFA
AJO, AZ, 23423

JONATHAN GUTIERREZ
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JONATHAN GUTIERREZ	*****0962

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

CHRISTOPHER BRETT
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTOPHER BRETT	*****7153

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

ELENA KHOPERSKAYA
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ELENA KHOPERSKAYA	*****4911

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2G	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	ELENA KHOPERSKAYA	*****4911		☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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JAMES WISWELL
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMES WISWELL	*****3081

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ANAND RAMASAMY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANAND RAMASAMY	*****0506

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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.

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Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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JOHN SELENSKY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN SELENSKY	*****5878

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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RONALD GYORFI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RONALD GYORFI	*****4090

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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CHRISTOPHER WHYTE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTOPHER WHYTE	*****3606

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ALEXIS WOLD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEXIS WOLD	*****8731

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

BEVERLY SEECHARRAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BEVERLY SEECHARRAN	*****7957

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2B	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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PRADEEP KUMAR
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PRADEEP KUMAR	*****3980

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
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	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

PATRICIA ROBERTSON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PATRICIA ROBERTSON	*****7229

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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STEFAN BOWERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STEFAN BOWERS	*****1900

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MARK BIERMAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARK BIERMAN	*****6687

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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RMS
sadfasdf ADFA
AJO, AZ, 23423

ALYSSA BRIGGS
1 Main St
GREER, RI, 12351

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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALYSSA BRIGGS	*****6377

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARK BEEZHOLD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARK BEEZHOLD	*****4071

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

JAIME BROWER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAIME BROWER	*****8803

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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JAMIE WHITE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JAMIE WHITE	*****9227

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RICHA MADAAN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RICHA MADAAN	*****2990

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

PREMILAN DURAIRAJ
1 Main St
GREER, RI, 12351

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sadfasdf ADFA
AJO, AZ, 23423

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
PREMILAN DURAIRAJ	*****6726

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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GREGORY HOLLINS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GREGORY HOLLINS	*****9013

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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GREER, RI, 12351

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RAHUL PANDEY	*****2427

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JESSICA HARKER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESSICA HARKER	*****0351

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

ALEX MASSOTH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEX MASSOTH	*****7251

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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DAVID KIRKLAND
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID KIRKLAND	*****5357

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
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AJO	AZ	23423

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JESSE HEBERT
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JESSE HEBERT	*****3665

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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KENT ARENDS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KENT ARENDS	*****4968

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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RAMESH VASIREDDY
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
RAMESH VASIREDDY	*****2983

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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VICENTE VALENCIA
1 Main St
GREER, RI, 12351

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sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VICENTE VALENCIA	*****7295

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	VICENTE VALENCIA	*****7295		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18	SANDRA DIEGUEZ	*****0547		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

OLEKSANDR KOVACH
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
OLEKSANDR KOVACH	*****7654

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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JUSTIN BENEDICK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JUSTIN BENEDICK	*****6038

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

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AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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MERRIE LAWTHER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MERRIE LAWTHER	*****7868

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Instructions for Recipient

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Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ADAM PLANETA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ADAM PLANETA	*****0654

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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ASHANTA WARRICK
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ASHANTA WARRICK	*****3854

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

MARK OLIVER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

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600117

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Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARK OLIVER	*****2127

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

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sadfasdf ADFA	2342342342

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AJO	AZ	23423

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	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

JOHN POSADA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JOHN POSADA	*****0910

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DANIEL COLON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DANIEL COLON	*****1804

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 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
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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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SYLVESTER COLLINS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
SYLVESTER COLLINS	*****8579

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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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)

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

BYRON FUNG
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BYRON FUNG	*****8708

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM FIORINO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM FIORINO	*****2755

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2B	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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STEPHANIE HARRIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
STEPHANIE HARRIS	*****8232

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	STEPHANIE HARRIS	*****8232		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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FE ANGELES
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
FE ANGELES	*****1978

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

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17	FE ANGELES	*****1978		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KENNETH LAND
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KENNETH LAND	*****0725

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

VENKATA PAMARAJU
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
VENKATA PAMARAJU	*****5393

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

MARGARITA MOLINA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARGARITA MOLINA	*****4595

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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DAVID HOFFARD
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID HOFFARD	*****6705

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ANDREW WILLIS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREW WILLIS	*****4802

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DEJUANN MURRELL
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DEJUANN MURRELL	*****2751

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2G	2G	2G	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ALEXANDER BERINATO
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ALEXANDER BERINATO	*****7518

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	ALEXANDER BERINATO	*****7518		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Part II. Employer Offer and Coverage, Lines 14-16.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

WILLIAM SEATON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
WILLIAM SEATON	*****5100

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	WILLIAM SEATON	*****5100		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

BRIAN MANEKE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
BRIAN MANEKE	*****6045

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

ROBERT FELCH
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ROBERT FELCH	*****6539

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Instructions for Recipient

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RMS
sadfasdf ADFA
AJO, AZ, 23423

CHRISTOPHER MONK
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CHRISTOPHER MONK	*****6040

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 months	**(e)** Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

DAVID GALE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID GALE	*****8075

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	DAVID GALE	*****8075		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KEVIN RUTROFF
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEVIN RUTROFF	*****5436

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DAVID MORGAN
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID MORGAN	*****5790

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

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Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

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	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

CAROLE KLANG
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
CAROLE KLANG	*****6015

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	CAROLE KLANG	*****6015		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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ANDREA NAVA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ANDREA NAVA	*****2243

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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JATIN TRIVEDI
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JATIN TRIVEDI	*****8752

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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MARY BRANNON
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
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Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARY BRANNON	*****3398

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	MARY BRANNON	*****3398		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

MARCUS WATSON
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
MARCUS WATSON	*****2719

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GEOFFREY HART
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GEOFFREY HART	*****4647

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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GILDA LOVKA
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GILDA LOVKA	*****2672

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GARY GREEN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GARY GREEN	*****1457

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 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.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

GARY SOMMER
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
GARY SOMMER	*****2501

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

KEITH DEVERE
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
KEITH DEVERE	*****5426

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

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ZHENYING CHEN
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
ZHENYING CHEN	*****2476

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

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 offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

Part I. Employee.

Lines 1-6. Part I, lines 1–6, reports information about you, the employee.
Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7–13, reports information about your employer
Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

Part II. Employer Offer and Coverage, Lines 14-16.

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

RMS
sadfasdf ADFA
AJO, AZ, 23423

DAVID CRAWFORD
1 Main St
GREER, RI, 12351

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

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Form **1095-C**
Department of the Treasury
Internal Revenue Service

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☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
DAVID CRAWFORD	*****0293

3 Street address (including apartment no.)
1 Main St

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11

	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)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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JENNIFER WITHERS
1 Main St
GREER, RI, 12351

RMS
sadfasdf ADFA
AJO, AZ, 23423

600117

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Department of the Treasury
Internal Revenue Service

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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
JENNIFER WITHERS	*****5740

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	RI	12351

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
RMS	23-4232222

9 Street address (including room or suite no.)	10 Contact telephone number
sadfasdf ADFA	2342342342

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
AJO	AZ	23423

Part II Employee Offer of Coverage

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	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	$	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$ 811.00	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	JENNIFER WITHERS	*****5740		☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐