

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5655	7 Name of employer Test Medical data responsible 1
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

 VOID

 CORRECTED

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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.

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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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- 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

Employer-Provided Health Insurance Offer and Coverage

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5656	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5657	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Applicable Large Employer Member (Employer)

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5658	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
45645			65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
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.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5659	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5660	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Applicable Large Employer Member (Employer)

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee
 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5661	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
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45645			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5662	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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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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 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.**Part I Employee**

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5663	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546	11 City or town ACTON	12 State or province CO
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

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Part III. Covered Individuals, Lines 17-22

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5664	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5665	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5666	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
45645			65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5667	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5668	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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 II I 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5670	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5672	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Dany Ni Kevin Jr	2 Social security number (SSN) *****5673	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5695	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Applicable Large Employer Member (Employer)

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

Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5696	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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1095-C
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 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage
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Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5697	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

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18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5698	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5699	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5700	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5701	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.**Part I Employee**

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5702	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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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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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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 (95% 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.

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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.

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Part III. Covered Individuals, Lines 17-22

Part II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5703	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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 (95% 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

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

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Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5704	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
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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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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5706	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
45645			65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5707	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 VOID CORRECTED

 OMB No. 1545-2251
2016

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5708	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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.

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5709	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5710	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5711	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

 VOID

 CORRECTED

 OMB No. 1545-2251
2016

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5712	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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. 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).

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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5734	7 Name of employer Test Medical data responsible 1
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5735	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5737	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5738	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5739	7 Name of employer Test Medical data responsible 1
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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.

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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.

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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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5740	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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)

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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 II I 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

► Do not attach to your tax return. Keep for your records.
Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5742	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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

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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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5743	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

 VOID

 CORRECTED

 OMB No. 1545-2251
2016

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5744	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5745	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

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2016
Employer-Provided Health Insurance Offer and Coverage

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Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5746	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
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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
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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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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

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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.

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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

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5747	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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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Employer-Provided Health Insurance Offer and Coverage

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Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5748	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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).

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 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 II I 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5750	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5751	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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Part III. Covered Individuals, Lines 17-22

Part II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5752	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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

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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5753	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

2016
Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5774	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5775	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5776	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5777	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12		9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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).

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 II I 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.

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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.

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.

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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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5779	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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).

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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5780	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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

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

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

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

1I. Your employer claimed "Qualifying Offer Transition Relief" for 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 II I 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5782	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5783	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5784	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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.

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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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5785	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5786	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5787	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5788	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5789	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12		9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5790	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5791	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
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.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5792	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5793	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5814	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5815	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5816	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5817	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5818	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5819	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5820	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5821	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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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 (95% 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).

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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5822	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III 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			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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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Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5824	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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

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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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5825	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5826	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5828	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5829	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.**Part I Employee**

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5830	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5831	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5832	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Applicable Large Employer Member (Employer)

Plan Start Month (Enter 2-digit number): 06													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5833	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5854	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
13 Country and ZIP or foreign postal code 65465			

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

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****58555	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5856	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5857	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

 VOID

 CORRECTED

OMB No. 1545-2251

2016
Applicable Large Employer Member (Employer)

7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546
11 City or town ACTON	12 State or province CO

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

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

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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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- 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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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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5858	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
45645			65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5859	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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).

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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5860	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5861	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5862	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
45645			65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5863	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

 VOID

 CORRECTED

OMB No. 1545-2251

2016

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5864	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5865	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Applicable Large Employer Member (Employer)

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code) 1G	15 Employee Required Contribution (see instructions) \$	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
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Part III Covered Individuals

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

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

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5866	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5867	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5868	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5869	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Applicable Large Employer Member (Employer)

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5870	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5872	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5873	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5894	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

Employer-Provided Health Insurance Offer and Coverage

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5895	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

Employer-Provided Health Insurance Offer and Coverage

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

Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.
Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5896	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5897	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5898	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5899	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5900	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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 II I 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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

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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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5902	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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

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Part III. Covered Individuals, Lines 17-22

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

Employer-Provided Health Insurance Offer and Coverage

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5903	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5904	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5905	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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.

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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5906	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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

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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

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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
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.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5908	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

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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			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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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.

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

1 Name of employee Dany Ni Kevin Jr	2 Social security number (SSN) *****5909	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	6 County and ZIP or foreign postal code 45645	11 City or town ACTON
			12 State or province CO
			13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5910	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5911	7 Name of employer Test Medical data responsible 1
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G													
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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- 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.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
2016

OMB No. 1545-2251

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

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5912	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5934	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5935	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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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- 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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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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

Employer-Provided Health Insurance Offer and Coverage

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5936	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5937	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5938	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5939	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

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.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5940	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
Applicable Large Employer Member (Employer)			
7 Name of employer Test Medical data responsible 1			
9 Street address (including room or suite no.) 123 465			
11 City or town ACTON			
12 State or province CO			
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

 Form **1095-C** (2016)

Test Medical data responsible 1
123 465
ACTON, CO, 65465

Dany Ni Kevin Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

Part I Employee

1 Name of employee Dany Ni Kevin Jr.	2 Social security number (SSN) *****5941	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	9 Street address (including room or suite no.) 123 465	10 Contact telephone number 6546546546	
4 City or town CAMBRIA	5 State or province CA	11 City or town ACTON	12 State or province CO
6 County and ZIP or foreign postal code 45645		13 Country and ZIP or foreign postal code 65465	

Applicable Large Employer Member (Employer)

2 Social security number (SSN) *****5941	7 Name of employer Test Medical data responsible 1											
4 City or town CAMBRIA	5 State or province CA											
6 County and ZIP or foreign postal code 45645	11 City or town ACTON											
	12 State or province CO											
Plan Start Month (Enter 2-digit number): 06												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1G												
15 Employee Required Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)												

Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Andy Ni Diesel Jr
12 12
CAMBRIA, CA, 45645

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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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 (95% 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 II I 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

Part I Employee

1 Name of employee Andy Ni Diesel Jr	2 Social security number (SSN) *****5942	7 Name of employer Test Medical data responsible 1
3 Street address (including apartment no.) 12 12	8 Employer identification number (EIN) 24-5654646	
4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546	
ACTON	11 City or town CO	12 State or province CO
		13 Country and ZIP or foreign postal code 65465

Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 06												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1G													
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brandy Ni Evan Jr
12 12
CAMBRIA, CA, 45645

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 (95% 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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1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED

 OMB No. 1545-2251
2016
Employer-Provided Health Insurance Offer and Coverage

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Brandy Ni Evan Jr	2 Social security number (SSN) *****5943	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
		6 County and ZIP or foreign postal code 45645	10 Contact telephone number 6546546546
		11 City or town ACTON	12 State or province CO
		13 Country and ZIP or foreign postal code 65465	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 06											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Candy Ni Kim Jr
12 12
CAMBRIA, CA, 45645

Instructions for Recipient

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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)

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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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that your employer has 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.

1095-C
 Form
 Department of the Treasury
 Internal Revenue Service

 VOID CORRECTED
 OMB No. 1545-2251

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

 ▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c.

Part I Employee

1 Name of employee Candy Nli Kim Jr	2 Social security number (SSN) *****5944	7 Name of employer Test Medical data responsible 1	8 Employer identification number (EIN) 24-5654646
3 Street address (including apartment no.) 12 12	4 City or town CAMBRIA	5 State or province CA	9 Street address (including room or suite no.) 123 465
6 County and ZIP or foreign postal code 45645	11 City or town ACTON	12 State or province CO	10 Contact telephone number 6546546546
13 Country and ZIP or foreign postal code 65465			

Part II Employee Offer of Coverage

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

Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

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