

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Nathan v Mescher Sr  
61 Division Street  
YUBA CITY, CA, 95993

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

# 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

### Part I Employee

1 Name of employee Nathan v Mescher Sr	2 Social security number (SSN) *****1710	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 61 Division Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town YUBA CITY	5 State or province CA	6 County and ZIP or foreign postal code 95993	11 City or town GREENVILLE
			12 State or province SC

### Part II Employee Offer of Coverage

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

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(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 Nathan v Mescher Sr	*****1710	11-05-1965	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Dominga p Mescher	*****2025	07-04-1997	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

Form **1095-C** (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Luetta f Forde  
73 Southampton Ave  
PASADENA, MD, 21122

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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

**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 Luetta f Forde	2 Social security number (SSN) *****7485	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 73 Southampton Ave	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town PASADENA MD	5 State or province 21122	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Luetta f Forde	*****7485	06-14-1989	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Abdul u Forde	*****9120	01-11-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Marylyn t Maple  
8964 Bellevue Ave  
SCARSDALE, NY, 10583

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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).

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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 <b>Marylyn t Maple</b>	2 Social security number (SSN) *****1936	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>8964 Bellevue Ave</b>	4 City or town <b>SCARSDALE</b>	5 State or province <b>NY</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>10583</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	13 Country and ZIP or foreign postal code 29607

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

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Marylyn t Maple	*****1936	05-27-1993	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Aldaj Maple	*****5376	08-27-1970	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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Cat. No. 60705M

VOID

CORRECTED

2016

OMB No. 1545-2251

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Gerri p McLennon Jr  
7337 Chapel St  
HOBART, IN, 46342

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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 <b>Gerrit McLennan Jr</b>	2 Social security number (SSN) *****6082	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>7337 Chapel St</b>	4 City or town <b>HOBART IN</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province <b>IN</b>	6 County and ZIP or foreign postal code <b>46342</b>	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Gerrit McLennan Jr	*****6082	09-22-1995	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Kyoko a McLennan	*****5107	11-17-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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

 VOID CORRECTED**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Socorro c Jaqua  
7278 Tailwater St  
TAYLORS, SC, 29687

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

**Line 10.** 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.

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

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

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

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

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

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

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

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

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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 SOCORRO C Jaqua	2 Social security number (SSN) *****8154	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7278 Tailwater St	4 City or town TAYLORS	5 State or province SC	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 29687	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (Enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Socorro c Jaqua	*****8154	06-06-1975	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Kimberly x Jaqua	*****8926	07-05-1978	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Ernie n Lamoureux  
8067 Tanglewood Street  
CORONA, NY, 11368

## 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.

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

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

**1A.** Minimum 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).

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Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Tressie h Yeats  
38 SW Elmwood St  
EASTON, PA, 18042

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

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

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

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

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

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

that your employer has 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

## 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 <b>Tressie h Yeats</b>	2 Social security number (SSN) *****6673	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>38 SW Elmwood St</b>	4 City or town <b>EASTON PA</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province <b>PA</b>	6 County and ZIP or foreign postal code <b>18042</b>	11 City or town <b>GREENVILLE SC</b>	12 State or province <b>SC</b>
13 Country and ZIP or foreign postal code <b>29607</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Tressie h Yeats	*****6673	10-19-1983	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Samantha Yeats	*****4795	09-23-1995	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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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**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Florinda g Mcveigh  
933 Spring Drive  
ATLANTIC CITY, NJ, 08401

## 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).

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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.  
**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**

**Part I Employee**

1 Name of employee Florinda g Mcveigh	2 Social security number (SSN) *****3598	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 933 Spring Drive	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town ATLANTIC CITY	5 State or province NJ	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 08401		13 Country and ZIP or foreign postal code 29607	

<b>Part II Employee Offer of Coverage</b>		<b>Plan Start Month</b> (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Florinda g Mcveigh	*****3598	12-17-1983	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Jewel e Mcveigh	*****5724	01-14-1973	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

VOID

CORRECTED

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Samella h Stmartin  
7010 Center Lane  
SHIRLEY, NY, 11967

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Samella h Stmartin	2 Social security number (SSN) *****5379	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7010 Center Lane		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town SHIRLEY	5 State or province NY	11 City or town GREENVILLE	12 State or province SC
11967			

**Applicable Large Employer Member (Employer)**

1 Name of employee Samella h Stmartin	2 Social security number (SSN) *****5379	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7010 Center Lane		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town SHIRLEY	5 State or province NY	11 City or town GREENVILLE	12 State or province SC
11967			

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Samella h Stmartin	*****5379	02-26-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Gidget d Stmartin	*****9242	03-03-1968	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Jenée t Landwehr  
9986 1st Street  
FORT DODGE, IA, 50501

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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

**Part I Employee**  
**Employee**
**Employer-Provided Health Insurance Offer and Coverage**

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

1 Name of employee Jenee t Landwehr	2 Social security number (SSN) *****4376	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9986 1st Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town FORT DODGE	5 State or province IA	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 50501		13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Jenee t Landwehr	*****4376	09-23-1995	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Socorro f Landwehr	*****6201	06-07-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Tiffany g Rosenberg  
7141 W Country Street  
STUART, FL, 34997

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Tiffany Q Rosenberg	2 Social security number (SSN) *****6841	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7141 W Country Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town STUART	5 State or province FL	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 34997		13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Tiffany Rosenberg	*****6841	12-13-1997	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Marguerite c Rosenberg	*****8296	05-08-1965	<input checked="" 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.

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Kyoko o Crompton  
8252 S Yukon Drive  
ELLENWOOD, GA, 30294

## Instructions for Recipient

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

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

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

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

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

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

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

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

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

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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 Kyoko O Crompton	2 Social security number (SSN) *****2820	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8252 S Yukon Drive	4 City or town ELLENWOOD	5 State or province GA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 30294	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Kyoko o Crompton	*****2820	07-15-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Marc f Crompton	*****1189	12-14-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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**

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Timothy r Fawley  
560 W Kirkland Street  
BUTLER, PA, 16001

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Timothy r Fawley	2 Social security number (SSN) *****9846	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 560 W Kirkland Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town BUTLER PA	5 State or province PA	11 City or town GREENVILLE SC	12 State or province SC
	6 County and ZIP or foreign postal code 16001		13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Timothy r Fawley	*****9846	12-18-1992	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Jaqueline h Fawley	*****8260	09-24-1987	<input checked="" 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

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Orpha g Frieden  
286 Galvin Street  
HONOLULU, HI, 96815

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Orpha Frieden	2 Social security number (SSN) *****9380	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 286 Galvin Street	4 City or town HONOLULU HI	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province HI	6 County and ZIP or foreign postal code 96815	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Orpha g Frieden	*****9380	05-16-1997	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Nam m Frieden	*****8992	12-14-1974	<input checked="" 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

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Conception d Dacus  
47 Westport Street  
NEW BRUNSWICK, NJ, 89010

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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

**Part I Employee**  
 VOID       CORRECTED

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.  
**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)**
**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****6476		7 Name of employer Brian's Testing Company 1		8 Employer identification number (EIN) 55-5515555	
3 Street address (including apartment no.) 47 Westport Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A		10 Contact telephone number 5555655555		13 Country and ZIP or foreign postal code 29607	
4 City or town NEW BRUNSWICK	5 State or province NJ	6 County and ZIP or foreign postal code 89010	11 City or town GREENVILLE	12 State or province SC	13 Country and ZIP or foreign postal code 29607		
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1A							
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C						

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Conception d Dacus	*****6476	09-16-1983	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Desiree h Dacus	*****6428	04-16-1998	<input checked="" 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"/>

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Melia d Ostroff  
193 Manhattan St  
OPA LOCKA, FL, 33054

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

**1A.** Minimum 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 Melia d Ostroff	2 Social security number (SSN) *****9429	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 193 Manhattan St	4 City or town OPA LOCKA FL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province FL	6 County and ZIP or foreign postal code 33054	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Melia d Ostroff	*****9429	04-16-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Timothy g Ostroff	*****0742	05-23-1990	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Johnna n Boller  
9 Taylor Drive  
CLIFTON PARK, NY, 12065

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Johnna n Boller	2 Social security number (SSN) *****8489	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9 Taylor Drive	4 City or town CLIFTON PARK	5 State or province NY	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 12065	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
14 Offer of Coverage (enter required code)	1A Months	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)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Johnna n Boller	*****8489	11-01-1996	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Orpha g Boller	*****8840	12-13-1997	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Debra b Maser  
9530 Tanglewood Dr  
PORTAGE, IN, 46368

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 <b>Debra b Maser</b>	2 Social security number (SSN) *****2539	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>9530 Tanglewood Dr</b>	4 City or town <b>PORTAGE</b>	5 State or province <b>IN</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>46368</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code <b>29607</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Debra b Maser	*****2539	07-06-1987	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Lea n Maser	*****9832	06-14-1989	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Maryjane x Spainhour  
9265 North Oak Dr  
NORTH HAVEN, CT, 64730

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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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

**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 Maryjane X Spainhour	2 Social security number (SSN) *****1960	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9265 North Oak Dr		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town NORTH HAVEN	5 State or province CT	11 City or town GREENVILLE SC	12 State or province SC
6 County and ZIP or foreign postal code 64730		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Maryjane X Spainhour	*****1960	10-22-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Gerri's Spainhour	*****0060	09-03-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Nam b Shaikh  
735 Princess Drive  
ONALASKA, WI, 54650

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

**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 Nam b Shaikh	2 Social security number (SSN) *****7981	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 735 Princess Drive	4 City or town ONALASKA	5 State or province WI	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
	6 County and ZIP or foreign postal code 54650	11 City or town GREENVILLE	10 Contact telephone number 5555655555
		12 State or province SC	13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Nam b Shaikh	*****7981	11-19-1999	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Tandra j Shaikh	*****7720	04-12-1991	<input checked="" 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)

 VOID

 CORRECTED

 OMB No. 1545-2251  
**2016**

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Ruthanne f Tomey  
449 West Rose Street Apt 18  
AMBLER, PA, 19002

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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 Ruthanne f Tomey	2 Social security number (SSN) *****7039	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 449 West Rose Street Apt 18	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town AMBLER PA	5 State or province PA	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 19002	14	15	16

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

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Ruthanne f Tomey	*****7039	07-09-1978	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Alaine j Tomey	*****0220	01-02-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Alda e Watters  
23 Primrose Street  
MAINEVILLE, OH, 45039

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

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

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

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# 1095-C

Form  
Department of the Treasury  
Internal Revenue Service

## Employer-Provided Health Insurance Offer and Coverage

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### Part I Employee

1 Name of employee Alda e Watters	2 Social security number (SSN) *****8743	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 23 Primrose Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town MAINEVILLE OH	5 State or province 45039	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Alda e Watters	*****8743	11-03-1975	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Enid w Watters	*****2854	10-19-1983	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
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Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Rozella k Dashner Jr  
213 Railroad Lane  
TOLEDO, OH, 43612

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# 1095-C

Form  
Department of the Treasury  
Internal Revenue Service

## Employer-Provided Health Insurance Offer and Coverage

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### Part I Employee

1 Name of employee Rozella k Dashner Jr	2 Social security number (SSN) *****5110	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 213 Railroad Lane		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town TOLEDO	5 State or province OH	11 City or town GREENVILLE	12 State or province SC
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)	17

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
Rozella k Dashner Jr	*****5110	05-21-1997	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
September f Dashner	*****5560	12-28-1977	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Abdul g Work  
9229 Second Drive  
ADRIAN, MI, 49221

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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 Abdul g Work	2 Social security number (SSN) *****0837	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9229 Second Drive	4 City or town ADRIAN	5 State or province MI	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 49221	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
			13 Country and ZIP or foreign postal code 29607

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Abdul g Work	*****0837	06-02-1977	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Jody j Work	*****5187	01-13-1998	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Inge g Mckinnis  
93 Surrey Ave  
BUTLER, PA, 16001

## Instructions for Recipient

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

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**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 Inge g Mckinnis  
 3 Street address (including apartment no.)  
 93 Surrey Ave  
 4 City or town  
 BUTLER PA  
 5 State or province  
 16001

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**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)	1A												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Inge g Mckinnis	*****7417	05-10-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Orville k Mckinnis	*****4300	07-09-1978	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Arlyne d Mccolley  
98 Glenridge Court  
WOODSIDE, NY, 11377

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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 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

**Part I Employee**  
 Name of employee  
 Arlyne d McColley  
 Street address (including apartment no.)  
 98 Glenridge Court  
 City or town  
 WOODSIDE NY  
 State or province  
 11377

**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](http://www.irs.gov/form1095c)**
**Part II Employee Offer of Coverage**

14 Offer of Coverage (Enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	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)	2D	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C

**Part III Covered Individuals**

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

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

 VOID

 CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Sharleen g Knaack  
7496 Creekside St  
EAST MEADOW, NY, 11554

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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 Sharleen g Knaack	2 Social security number (SSN) *****7604	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7496 Creekside St		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town EAST MEADOW	5 State or province NY	11 City or town GREENVILLE SC	12 State or province SC
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C													

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Sharleen g Knaack	*****7604	08-01-1966	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Glenna c Knaack	*****3143	06-14-1989	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Florentino y Leeper  
96 Cypress Road  
SAN PABLO, CA, 94806

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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**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 Florentino y Leeper	2 Social security number (SSN) *****5446	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 96 Cypress Road	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town SAN PABLO CA	5 State or province CA	11 City or town GREENVILLE SC	12 State or province SC
6 County and ZIP or foreign postal code 94806		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
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 Florentino y Leeper	*****5446	09-03-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Vesta y Leeper	*****6614	08-28-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Tora d Lumb II  
62 Amerige St  
VICTORIA, TX, 77904

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Tora d Lumb II	2 Social security number (SSN) *****4084	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 62 Amerige St	4 City or town VICTORIA	5 State or province TX	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 77904	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C											

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Tora d Lumb II	*****4084	01-21-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Merrie r Lumb	*****6880	05-16-1997	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Holley v Ham  
9058 Windsor Drive  
ROYERSFORD, PA, 19468

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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**  
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**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**

**Part I Employee**

1 Name of employee Holley V Ham	2 Social security number (SSN) *****1065	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9058 Windsor Drive	4 City or town ROYERSFORD PA	5 State or province PA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 19468	11 City or town GREENVILLE SC	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	1A	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Holley v Ham	*****1065	11-15-1974	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Wilhelmina g Ham	*****7228	11-03-1968	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Verona w Radosevich  
792 Harvard Dr  
Newark, NJ, 80969

## Instructions for Recipient

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

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**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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](http://www.irs.gov/form1095c).**
**Part I Employee**

1 Name of employee Verona W Radosevich	2 Social security number (SSN) *****2597	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 792 Harvard Dr	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town Newark NJ	5 State or province 80969	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Verona w Radosevich	*****2597	04-30-1996	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Holley c Radosevich	*****9110	05-27-1993	<input checked="" 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

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

King h Job  
7421 East Columbia St  
DUBUQUE, IA, 52001

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 King h Job	2 Social security number (SSN) *****2727	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7421 East Columbia St	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town DUBUQUE	5 State or province IA	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 52001		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 King h Job	*****2727	05-18-1982	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Melda s Job	*****6956	10-31-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

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

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Taina d Pier	2 Social security number (SSN) *****6949	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 209 Country Club Ave Apt B	4 City or town GLEN COVE	5 State or province NY	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 11542	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Taina d Pier	*****6949	08-31-1999	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Clarice h Pier	*****6814	10-07-1993	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Krystina g Plant  
9622 Winchester Road  
EASTON, PA, 18042

## Instructions for Recipient

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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 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 Krystina g Plant	2 Social security number (SSN) *****1308	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9622 Winchester Road	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town EASTON PA	5 State or province 18042	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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 Krystina g Plant	*****1308	01-14-1974	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Suk Plant	*****0885	06-29-1971	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Cory w Jowett  
68 Oak Valley Court  
HAINES CITY, FL, 33844

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**Part I Employee**

1 Name of employee <b>Cory W Jowett</b>	2 Social security number (SSN) *****8311	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>68 Oak Valley Court</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town <b>HAINES CITY FL</b>	5 State or province <b>33844</b>	11 City or town GREENVILLE SC	12 State or province SC
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)	17

**Part II Employee Offer of Coverage**

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

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

(a) Name of covered individual(s)	(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 Cory w Jowett	*****8311	06-14-1989	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Nathan u Jowett	*****2225	06-09-1965	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Glenna j Dark  
65 Middle River Court  
LONG BRANCH, NJ, 77400

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

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**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.

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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](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Glenna J Dark	2 Social security number (SSN) *****7080	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555									
3 Street address (including apartment no.) 65 Middle River Court	4 City or town LONG BRANCH NJ	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555									
5 State or province NJ	6 County and ZIP or foreign postal code 77400	11 City or town GREENVILLE SC	12 State or province SC									
<b>Plan Start Month</b> (Enter 2-digit number): 04												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1A												
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Dennis g Wimbley  
7849 Bohemia Drive  
HASTINGS, MN, 55033

## 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

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 Dennis g Wimbley	2 Social security number (SSN) *****4593	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7849 Bohemia Drive		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town HASTINGS	5 State or province MN	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 55033		13 Country and ZIP or foreign postal code 29607	

**Applicable Large Employer Member (Employer)**

2 Social security number (SSN) *****4593	7 Name of employer Brian's Testing Company 1
	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
	11 City or town GREENVILLE
	12 State or province SC
	13 Country and ZIP or foreign postal code 29607

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Dennis g Wimbley	*****4593	08-28-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Magen c Wimbley	*****3890	04-04-1969	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Su u Benoit  
33 Pawnee Ave  
RAPID CITY, SD, 57701

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

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

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

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

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

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

**Part I Employee**
**Employer-Provided Health Insurance Offer and Coverage**

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).
**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****5560		7 Name of employer Brian's Testing Company 1		8 Employer identification number (EIN) 55-5515555	
3 Street address (including apartment no.) 33 Pawnee Ave		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A		10 Contact telephone number 5555655555		13 Country and ZIP or foreign postal code 29607	
4 City or town RAPID CITY SD	5 State or province 57701	6 County and ZIP or foreign postal code GREENVILLE SC	11 City or town GREENVILLE SC	12 State or province SC	13 Country and ZIP or foreign postal code 29607		
<b>Part II Employee Offer of Coverage</b>							
14 Offer of coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1A							
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H						

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

(a) Name of covered individual(s)	(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"/>

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Gudrun j Lapp  
30 East Fawn Street  
MOUNT HOLLY, NJ, 80609

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Gudrun j Lapp	2 Social security number (SSN) *****8449	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 30 East Fawn Street	4 City or town MOUNT HOLLY NJ	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province NJ	6 County and ZIP or foreign postal code 80609	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Gudrun j Lapp	*****8449	10-07-1993	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Conception n Lapp	*****3624	10-14-1996	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Justine I Soja  
8267 W Vermont Drive  
INDIAN TRAIL, NC, 28079

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

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

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

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

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

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

that your employer has 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

**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 Justine I Soja	2 Social security number (SSN) *****3016	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8267 W Vermont Drive	4 City or town INDIAN TRAIL NC	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province NC	6 County and ZIP or foreign postal code 28079	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1A	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Required Contribution (see instructions) \$													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C													

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Justine I Soja	*****3016	12-19-1988	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Dominga r Soja	*****7352	04-30-1996	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Alaine a Lemaster  
858 Wentworth Lane  
RALEIGH, NC, 27603

## Instructions for Recipient

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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

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

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

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

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

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

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

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

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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  
 ▶ Do not attach to your tax return. Keep for your records.  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

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**Part I Employee**

1 Name of employee Alaine a Lemaster	2 Social security number (SSN) *****7326	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 858 Wentworth Lane	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town RALEIGH NC	5 State or province 27603	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Alaine a Lemaster	*****7326	10-02-1966	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Maren n Lemaster	*****0780	08-06-1991	<input checked="" 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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Mittie f Sisk  
9096 West Spruce Court  
KALAMAZOO, MI, 49009

## 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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 Mittie f Sisk	2 Social security number (SSN) *****7526	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9096 West Spruce Court	4 City or town KALAMAZOO	5 State or province MI	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 49009	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Mittie f Sisk	*****7526	04-12-1991	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Rozella d Sisk	*****1083	11-11-1966	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Tandra f Summers  
497 Redwood Ave  
GIBSONIA, PA, 15044

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Tandra f Summers	2 Social security number (SSN) *****1901	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 497 Redwood Ave		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town GIBSONIA PA	5 State or province PA	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Tandra f Summers	*****1901	10-08-1996	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Tiffany Summers	*****1650	05-21-1997	<input checked="" 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

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Hugo s Garnes  
50 Fordham Drive  
NORCROSS, GA, 30092

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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](http://www.irs.gov/form1095c)
**Part I Employee**

1 Name of employee <b>Hugo S Garnes</b>	2 Social security number (SSN) *****0250	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>50 Fordham Drive</b>	4 City or town <b>NORCROSS</b>	5 State or province <b>GA</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>30092</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code <b>29607</b>			

<b>Part II Employee Offer of Coverage</b>		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Hugo s Garnes	*****0250	09-24-1987	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Justine d Garnes	*****9628	03-31-2000	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

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

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Crista b Horiuchi	2 Social security number (SSN) *****0247	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 258 Oak Meadow Avenue	4 City or town LANSDOWNE PA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province PA	6 County and ZIP or foreign postal code 19050	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Crista b Horiuchi	*****0247	10-14-1996	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Meliat Horiuchi	*****4748	10-09-1987	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Shelton h Hafley  
7641 Washington Drive  
PRATTVILLE, AL, 36067

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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).

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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 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 Shelton h Hafley	2 Social security number (SSN) *****6668	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7641 Washington Drive	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town PRATTVILLE	5 State or province AL	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 36067	7 Country and ZIP or foreign postal code 29607	13 Country and ZIP or foreign postal code 29607	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Shelton h Hafley	*****6668	11-11-1966	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Karena g Hafley	*****3020	12-17-1983	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Daniella j Selvage  
8178 Military St  
Newark, NJ, 80960

## 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

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

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

**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 Daniella j Selvage	2 Social security number (SSN) *****5803	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8178 Military St		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town Newark NJ	5 State or province 80960	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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 Daniella j Selvage	*****5803	05-16-1973	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Inge j Selvage	*****1403	01-13-1993	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Yetta c Rasberry  
8846 Greenview Ave  
ELIZABETH CITY, NC, 27909

## 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).

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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).

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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](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Yetta C Raspberry	2 Social security number (SSN) *****3530	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8846 Greenview Ave	4 City or town ELIZABETH CITY	5 State or province NC	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 27909	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	

<b>Part II Employee Offer of Coverage</b>		Plan Start Month (Enter 2-digit number): 04											
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Yetta c Raspberry	*****3530	12-08-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Dennis t Raspberry	*****7612	05-10-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Jordon g Eichorn  
8332 Harvard Lane  
SHEBOYGAN, WI, 53081

## Instructions for Recipient

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Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Regenia r Arter  
7483 Thatcher Street  
DELAWARE, OH, 43015

## 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.

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

**Part I Employee**  
 Name of employee  
 Regenia r Arter  
 Street address (including apartment no.)  
 7483 Thatcher Street

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.  
**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)**
**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Desiree t Borkowski  
9538 Applegate St  
HERNANDO, MS, 38632

## Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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

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

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

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

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

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

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

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

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

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

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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**Employer-Provided Health Insurance Offer and Coverage**

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**Part I Employee**

1 Name of employee Desiree t Borkowski	2 Social security number (SSN) *****6662	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9538 Applegate St	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town HERNANDO MS	5 State or province 38632	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Desiree t Borkowski	*****6662	06-29-1971	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Keesha m Borkowski	*****1647	12-18-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Gidget f Lile  
13 Marconi Rd  
MCALLEN, TX, 78501

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

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

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

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

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

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

that your employer has 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

**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 Gidget f Lile	2 Social security number (SSN) *****8475	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 13 Marconi Rd	4 City or town MCALLEN TX	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province TX	6 County and ZIP or foreign postal code 78501	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Gidget f Lile	*****8475	03-05-1973	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Gary r Lile	*****3060	05-18-1982	<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Shasta k Rowe  
655 Proctor Drive  
SOUTHAMPTON, PA, 18966

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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 Shasta K Rowe	2 Social security number (SSN) *****6308	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 655 Proctor Drive	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town SOUTHAMPTON PA	5 State or province 18966	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1A												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C											

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Shasta k Rowe	*****6308	06-07-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Stevie i Rowe	*****0795	08-29-1994	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Regina a Schull  
98 NE Water Dr  
WEST FARGO, ND, 58078

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Regina a Schull	2 Social security number (SSN) *****8180	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 98 NE Water Dr	4 City or town WEST FARGO	5 State or province ND	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 58078	11 City or town GREENVILLE
			12 State or province SC

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1A												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Regina a Schull	*****8180	03-21-1979	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Kathi q Schull	*****2596	08-20-1968	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

### Applicable Large Employer Member (Employer)

8 Name of employer Brian's Testing Company 1
9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
10 Contact telephone number 5555655555

13 Country and ZIP or foreign postal code  
29607

11 City or town  
GREENVILLE

12 State or province  
SC

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Wilhelmina c Whisenhunt  
459 Manor St  
JONESBORO, GA, 30236

## 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 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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.

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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 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 Wilhelmina C Whisenhunt	2 Social security number (SSN) *****8686	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 459 Manor St		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town JONESBORO	5 State or province GA	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 30236		13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1A												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Wilhelmina c Whisenhunt	*****8686	04-01-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Alfonso j Whisenhunt	*****3590	04-04-1979	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Enid s Penhollow Jr  
8248 SE Campfire Road  
BOYNTON BEACH, FL, 33435

## Instructions for Recipient

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

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

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

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

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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

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

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

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 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Enid S Penhollow Jr	2 Social security number (SSN) *****6439	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8248 SE Campfire Road	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town BOYNTON BEACH FL	5 State or province 33435	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Enid S Penhollow Jr	*****6439	04-04-1979	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Regina v Penhollow	*****8280	12-11-1997	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Harrison d Carmen  
50 Greystone Dr  
LEVITTOWN, NY, 11756

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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 Harrison d Carmen	2 Social security number (SSN) *****3168	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 50 Greystone Dr	4 City or town LEVITTOWN	5 State or province NY	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 11756	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Harrison d Carmen	*****3168	08-29-1994	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Cassandra t Carmen	*****9380	03-05-1973	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Dominga q Cassette  
8335 Courtland Street  
FAIRPORT, NY, 14450

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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

**Part I Employee**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.  
**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)**
**Applicable Large Employer Member (Employer)**

1 Name of employee Dominga q Cassette	2 Social security number (SSN) *****4677	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8335 Courtland Street	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	13 Country and ZIP or foreign postal code 29607
4 City or town AIRPORT	5 State or province NY	6 County and ZIP or foreign postal code 14450	11 City or town GREENVILLE
			12 State or province SC

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Dominga q Cassette	*****4677	10-31-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Roxanna t Cassette	*****1833	06-26-1968	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Marc i Jaycox  
67 Greystone Dr  
MISHAWAKA, IN, 46544

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 <b>Marc i Jaycox</b>	2 Social security number (SSN) *****1174	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>67 Greystone Dr</b>	4 City or town <b>MISHAWAKA IN</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province <b>IN</b>	6 County and ZIP or foreign postal code <b>46544</b>	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Marc i Jaycox	*****1174	12-07-1967	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Florentino h Jaycox	*****8793	12-08-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Clarice e Mirabella  
7568 Ohio Lane  
WILSON, NC, 27893

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

Part 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).
**Part I Employee**

1 Name of employee Clarice e Mirabella	2 Social security number (SSN) *****1195	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7568 Ohio Lane		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town WILSON NC	5 State or province 27893	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

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

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

(a) Name of covered individual(s)	(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 Clarice e Mirabella	*****1195	02-08-1965	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Krystina f Mirabella	*****3408	09-16-1983	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Alfonso x Pippenger  
87 Country Drive  
SIOUX CITY, IA, 51106

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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](http://www.irs.gov/form1095c).**Part I Employee**

1 Name of employee Alfonso X Pippenger	2 Social security number (SSN) *****8960	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 87 Country Drive	4 City or town SIOUX CITY IA	5 State or province IA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 51106	11 City or town GREENVILLE SC	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

Applicable Large Employer Member (Employer)													
Plan Start Month (Enter 2-digit number): 04													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1A													
15 Employee Contribution (see instructions) \$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C													

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

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

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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Cassandra r Easterly III  
89 Newport St  
MIDLAND, MI, 48640

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Cassandra r Easterly III	2 Social security number (SSN) *****9367	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 89 Newport St		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town MIDLAND MI	5 State or province 48640	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

2 Social security number (SSN) *****9367	3 Street address (including apartment no.) 89 Newport St	4 City or town MIDLAND MI	5 State or province 48640	6 County and ZIP or foreign postal code GREENVILLE SC	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555	
						9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
						11 City or town GREENVILLE SC	12 State or province SC
						13 Country and ZIP or foreign postal code 29607	

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Cassandra r Easterly III	*****9367	01-11-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Ivey j Easterly	*****7449	10-10-1975	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Lashanda b Holman  
178 Green Lake Ave  
WEST BEND, WI, 53095

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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 Lashanda b Holman	2 Social security number (SSN) *****9168	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 178 Green Lake Ave		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town WEST BEND	5 State or province WI	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 53095		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Lashanda b Holman	*****9168	06-26-1968	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Ivan x Holman	*****1999	09-22-1995	<input checked="" 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

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Jody k Haynie  
8927 West Pennington Drive  
MUNDELEIN, IL, 60060

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Jody K Haynie	2 Social security number (SSN) *****5428	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8927 West Pennington Drive	4 City or town MUNDELEIN IL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province IL	6 County and ZIP or foreign postal code 60060	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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 Jody K Haynie	*****5428	01-14-1973	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Harrison d Haynie	*****1514	02-26-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Ivey v Cress  
8984 Griffin Drive  
FAIRFAX, VA, 22030

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Ivey v Cress	2 Social security number (SSN) *****2557	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8984 Griffin Drive	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town AIRFAAX	5 State or province VA	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 22030	7	8	13 Country and ZIP or foreign postal code 29607

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1A	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions) \$													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C													

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

(a) Name of covered individual(s)	(b) SSN or other TIN *****2557	(c) DOB (If SSN or other TIN is not available) 01-13-1998	(d) Covered all 12 months <input checked="" type="checkbox"/>	(e) Months of Coverage Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
17 Ivey v Cress			<input checked="" type="checkbox"/>	<input type="checkbox"/>
18 Samella b Cress	*****1117	08-01-1966	<input checked="" type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Kathi f Brindle  
9476 Forest St  
NEWARK, NJ, 07103

## 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.

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

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

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

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

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

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

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

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Part 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 <b>Kathif Brindle</b>	2 Social security number (SSN) *****5921	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>9476 Forest St</b>	4 City or town <b>NEWARK NJ</b>	5 State or province <b>NJ</b>	6 County and ZIP or foreign postal code <b>07103</b>
9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	11 City or town GREENVILLE SC	12 State or province SC	13 Country and ZIP or foreign postal code 29607

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Kathif Brindle	*****5921	08-27-1970	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Tressie x Brindle	*****6949	10-12-1987	<input checked="" 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

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Chris t Stroh  
38 Manchester St  
STATESVILLE, NC, 28625

## 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.

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

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

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

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

Part 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](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Chris t Stroh	2 Social security number (SSN) *****6334	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 38 Manchester St	4 City or town STATEVILLE NC	5 State or province NC	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 28625	11 City or town GREENVILLE SC	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C											

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Chris t Stroh	*****6334	06-09-1965	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Tessa v Stroh	*****7816	01-15-1972	<input checked="" 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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Magen m Haigh  
7212 New Circle  
PALM HARBOR, FL, 34683

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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 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 Magen m Haigh	2 Social security number (SSN) *****7886	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 7212 New Circle	4 City or town PALM HARBOR	5 State or province FL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 34683	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	14 Offer of Coverage (enter required code)

### Part II Employee Offer of Coverage

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

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Magen m Haigh	*****7886	01-16-1996	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Daniella n Haigh	*****8820	02-22-1993	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Roger f Ovalle  
35 Johnson Rd  
FLEMING ISLAND, FL, 32003

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).
**Part I Employee**

1 Name of employee Rodger f Ovalle	2 Social security number (SSN) *****2981	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 35 Johnson Rd	4 City or town FLEMING ISLAND	5 State or province FL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
	6 County and ZIP or foreign postal code 32003	11 City or town GREENVILLE	10 Contact telephone number 5555655555
		12 State or province SC	13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Rodger f Ovalle	*****2981	01-15-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Maryjane e Ovalle	*****1484	12-07-1967	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

September I Miyashiro  
8933 E Johnson Street  
NEWARK, NJ, 71030

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee September I Miyashiro	2 Social security number (SSN) *****3276	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8933 E Johnson Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town NEWARK	5 State or province NJ	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 71030		13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (Enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 September I Miyashiro	*****3276	05-08-1965	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Guillermina a Miyashiro	*****5683	07-06-1987	<input checked="" 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)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Vesta r Swinton  
67 Alton Street  
STUART, FL, 34997

## Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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 10.** 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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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has 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

## 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 <b>Vesta r Swinton</b>	2 Social security number (SSN) *****4375	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>67 Alton Street</b>	4 City or town <b>STUART</b>	5 State or province <b>FL</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code <b>34997</b>	10 Contact telephone number 5555655555
		11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Vesta r Swinton	*****4375	11-17-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Viola d Swinton	*****2847	01-16-1996	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Rebeca a Meisinger  
543 Arlington Street  
BROWNSBURG, IN, 46112

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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.

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

 VOID       CORRECTED  
 ▶ Do not attach to your tax return. Keep for your records.  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee <b>Rebecca a Meisinger</b>	2 Social security number (SSN) *****2711	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>543 Arlington Street</b>	4 City or town <b>BROWNSBURG</b>	5 State or province <b>IN</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>46112</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code <b>29607</b>			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C											

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Rebecca a Meisinger	*****2711	05-23-1990	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Hugo k Meisinger	*****6357	06-10-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Alysha p Guillen  
9323 Pumpkin Hill Rd  
NEWPORT NEWS, VA, 23601

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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  
 ▶ Do not attach to your tax return. Keep for your records.  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Alysha p Guillen	2 Social security number (SSN) *****7552	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9323 Pumpkin Hill Rd	4 City or town NEWPORT NEWS	5 State or province VA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 23601	11 City or town GREENVILLE	12 State or province SC	13 Country and ZIP or foreign postal code 29607

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Alysha p Guillen	*****7552	06-10-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Damien h Guillen	*****3799	04-01-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Damien t Scheuermann  
42 Manor St  
QUAKERTOWN, PA, 18951

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).
**Part I Employee**

1 Name of employee Damien t Scheuermann	2 Social security number (SSN) *****7271	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 42 Manor St	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town QUAKERTOWN PA	5 State or province 18951	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
14 Offer of Coverage (enter required code)	1A	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)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Damien t Scheuermann	*****7271	03-31-2000	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Verona f Scheuermann	*****8015	09-01-1992	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID CORRECTEDOMB No. 1545-2251  
**2016**

# Brian's Testing Company 1

## 18 Interchange Blvd Suite A

### GREENVILLE, SC, 29607

Marti j Kilgore  
34 Bridgeton Dr  
WEST CHICAGO, IL, 60185

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 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

**Part I Employee**  
 1 Name of employee  
 Marti J Kilgore  
 3 Street address (including apartment no.)  
 34 Bridgeton Dr  
 4 City or town  
 WEST CHICAGO IL  
 5 State or province  
 IL  
 6 County and ZIP or foreign postal code  
 60185

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****2313	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.)	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town	11 City or town GREENVILLE SC	12 State or province SC	13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1A												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Marti J Kilgore	*****2313	03-29-1988	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Shasta o Kilgore	*****3101	02-09-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Jacqueline h Feldmann  
9109 Maple Ave  
CLARKSTON, MI, 48348

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Jaqueline h Feldmann	2 Social security number (SSN) *****9520	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 9109 Maple Ave	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town CLARKSTON	5 State or province MI	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 48348		13 Country and ZIP or foreign postal code 29607	

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	1A												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C													

**Part III Covered Individuals**

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

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

 VOID       CORRECTED

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Dominga u Demello  
41 Hickory Ave  
AMSTERDAM, NY, 12010

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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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

## Employer-Provided Health Insurance Offer and Coverage

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

### Part I Employee

1 Name of employee Dominga u Demello	2 Social security number (SSN) *****7720	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 41 Hickory Ave	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town AMSTERDAM	5 State or province NY	11 City or town GREENVILLE	12 State or province SC
13 Country and ZIP or foreign postal code 12010	14	15	16

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C											

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Dominga u Demello	*****7720	11-16-1970	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Alysha v Demello	*****8417	11-15-1974	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Angele j Delaughter  
8456 Division Drive  
KERNERSVILLE, NC, 27284

## Instructions for Recipient

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### Part I. Employee.

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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

that your employer has 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  
 ▶ Do not attach to your tax return. Keep for your records.  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Angèle j Delaughter	2 Social security number (SSN) *****3764	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8456 Division Drive	4 City or town KERNERSVILLE	5 State or province NC	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 27284	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (Enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Angèle j Delaughter	*****3764	08-29-1994	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Johnna c Delaughter	*****1124	10-08-1996	<input checked="" 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.

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Karena m Rahm  
564 Kirkland Ave  
CHARLOTTE, NC, 28205

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

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

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

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

### Part I Employee

1 Name of employee <b>Karenam Rahm</b>	2 Social security number (SSN) *****6015	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>564 Kirkland Ave</b>	4 City or town <b>CHARLOTTE NC</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province <b>NC</b>	6 County and ZIP or foreign postal code <b>28205</b>	11 City or town <b>GREENVILLE SC</b>	12 State or province <b>SC</b>
13 Country and ZIP or foreign postal code <b>29607</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Karenam Rahm	*****6015	12-28-1977	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Debra y Rahm	*****0580	01-31-1972	<input checked="" 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)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Viola f Victor  
594 Thorne Avenue  
LANSDALE, PA, 19446

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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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Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Samantha y Paules  
953 Pine Ave  
RIVERDALE, GA, 30274

## 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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**1A.** Minimum 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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Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Kimberly n Sorrentino  
8138 Bear Hill Court  
JACKSON, NJ, 85270

## Instructions for Recipient

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

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

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

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

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

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

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

that your employer has 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**Employer-Provided Health Insurance Offer and Coverage**

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

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**Part I Employee**

1 Name of employee <b>Kimberly n Sorrentino</b>	2 Social security number (SSN) *****6118	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>8138 Bear Hill Court</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town <b>JACKSON NJ</b>	5 State or province <b>85270</b>	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Kimberly n Sorrentino	*****6118	09-27-1984	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Marti p Sorrentino	*****3820	01-21-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Jewel h Legg  
76 Bridle Street  
GARNER, NC, 27529

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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.

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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 Jewell h Legg	2 Social security number (SSN) *****1364	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 76 Bridle Street	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town GARNER NC	5 State or province 27529	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Jewell h Legg	*****1364	01-31-1972	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Luetta g Legg	*****2148	08-29-1994	<input checked="" 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

Form 1095-C (2016)

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Tessa k Farquhar  
43 Lafayette Ave  
ASHEBORO, NC, 27205

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 <b>Tessa k Farquhar</b>	2 Social security number (SSN) *****1292	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>43 Lafayette Ave</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town <b>ASHEBORO NC</b>	5 State or province <b>27205</b>	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

2 Social security number (SSN) *****1292	7 Name of employer Brian's Testing Company 1
6 County and ZIP or foreign postal code 27205	8 Employer identification number (EIN) 55-5515555
10 Contact telephone number 5555655555	11 City or town GREENVILLE SC
12 State or province SC	13 Country and ZIP or foreign postal code 29607

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

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Tessa k Farquhar	*****1292	07-04-1997	<input checked="" type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
18 Lashanda c Farquhar	*****1099	10-22-1972	<input checked="" type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
19			<input type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
20			<input type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
21			<input type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
22			<input type="checkbox"/>	<input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Merrie g Franck  
9283 William Street  
ROSELLE, IL, 60172

## 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

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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 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  
Merrie g Franck  
**3** Street address (including apartment no.)  
9283 William Street  
**4** City or town  
ROSELLE IL

**2** Social security number (SSN)  
\*\*\*\*\*0854

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Merrie g Franck	*****0854	02-09-1972	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Angele f Franck	*****5983	11-19-1999	<input checked="" 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

VOID       CORRECTED

**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Maren e Fuqua  
88 Ashley Drive  
BLACKWOOD, NJ, 80129

## Instructions for Recipient

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### Part I. Employee.

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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

**Part I Employee**

1 Name of employee Maren E Fuqua	2 Social security number (SSN) *****4218	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 88 Ashley Drive	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town BLACKWOOD	5 State or province NJ	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 80129		13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Maren e Fuqua	*****4218	06-18-1976	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Jordon g Fuqua	*****3102	08-31-1999	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19				<input type="checkbox"/> <input type="checkbox"/>
20				<input type="checkbox"/> <input type="checkbox"/>
21				<input type="checkbox"/> <input type="checkbox"/>
22				<input type="checkbox"/> <input type="checkbox"/>

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

Cat. No. 60705M

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Lise y Lemasters Sr  
8767 Rose Avenue  
BRANFORD, CT, 64059

## Instructions for Recipient

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

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

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

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Lise Y Lemasters Sr	2 Social security number (SSN) *****4514	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8767 Rose Avenue	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town BRANFORD	5 State or province CT	11 City or town GREENVILLE	12 State or province SC
6 County and ZIP or foreign postal code 64059		13 Country and ZIP or foreign postal code 29607	

<b>Part II Employee Offer of Coverage</b>		<b>Plan Start Month</b> (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Lise Y Lemasters Sr	*****4514	01-02-1972	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Ernie f Lemasters	*****0411	01-14-1974	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

 Form **1095-C** (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Melda j Pennebaker  
3 W Green Hill Dr  
SCHERERVILLE, IN, 46375

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 Melda J Pennebaker  
 3 Street address (including apartment no.)  
 3 W Green Hill Dr  
 4 City or town  
 SCHERERVILLE IN  
**Part II Employee Offer of Coverage**

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

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

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

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****0449	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.)	4 Street address (including room or suite no.)	9 Contact telephone number 5555655555	10 Contact telephone number 5555655555
4 City or town	5 State or province	11 City or town GREENVILLE SC	12 State or province SC

**Plan Start Month (Enter 2-digit number): 04**

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

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Melda J Pennebaker	*****0449	04-22-1998	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Cory I Pennebaker	*****2659	03-28-1990	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Marguerite h Deberry  
694 Sunset Road  
CHESHIRE, CT, 06410

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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.

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**Part I Employee**

1 Name of employee <b>Marguerite h Deberry</b>	2 Social security number (SSN) *****1042	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>694 Sunset Road</b>	4 City or town <b>CHESHIRE</b>	5 State or province <b>CT</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>06410</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	10 Contact telephone number 5555655555
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Marguerite h Deberry	*****1042	12-14-1974	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Mittie d Deberry	*****4006	02-12-1986	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID CORRECTEDOMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Stevie g Crothers  
42 Cambridge Dr  
COCOA, FL, 32927

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Stevie G Crothers	2 Social security number (SSN) *****7917	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 42 Cambridge Dr	4 City or town COCOA FL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province FL	6 County and ZIP or foreign postal code 32927	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Stevie g Crothers	*****7917	07-05-1978	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Tora y Crothers	*****6383	11-01-1996	<input checked="" 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

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Gary c Cortez  
29 W Chestnut Dr  
GRAND FORKS, ND, 58201

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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

 VOID       CORRECTED  
 OMB No. 1545-2251

**Part I Employee**
**Employer-Provided Health Insurance Offer and Coverage**

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

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

1 Name of employee Gary C Cortez	2 Social security number (SSN) *****6728	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 29 W Chestnut Dr	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555	
4 City or town GRAND FORKS ND	5 State or province 58201	11 City or town GREENVILLE SC	12 State or province SC
			13 Country and ZIP or foreign postal code 29607

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Gary c Cortez	*****6728	10-10-1975	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Sharleen h Cortez	*****0614	04-22-1998	<input checked="" 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.

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Keesha j Garlock  
24 Ramblewood St  
HELENA, MT, 59601

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

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

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

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

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

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

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

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

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

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

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

 VOID       CORRECTED  
 ▶ Do not attach to your tax return. Keep for your records.  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Part I Employee**

1 Name of employee Keesha j Garlock	2 Social security number (SSN) *****4146	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 24 Ramblewood St	4 City or town HELENA MT	5 State or province 59601	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code GREENVILLE SC	10 Contact telephone number 5555655555
		11 City or town GREENVILLE SC	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Keesha j Garlock	*****4146	04-01-1970	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Crista b Garlock	*****5787	03-15-1999	<input checked="" 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.

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Guillermina n Pugh  
756 Birchwood St  
PITTSFORD, NY, 14534

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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

**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 Guillermina n Pugh	2 Social security number (SSN) *****1518	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 756 Birchwood St		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town PITTSFORD	5 State or province NY	11 City or town GREENVILLE	12 State or province SC
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)	17
All 12 Months	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec	\$ \$ \$ \$ \$	\$ \$ \$ \$ \$

**Part II Employee Offer of Coverage**

		Plan Start Month (Enter 2-digit number): 04											
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
2C													

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Guillermina n Pugh	*****1518	02-12-1986	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Shelton e Pugh	*****5663	01-15-1987	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Leonie d Stpeter  
31 Lexington St  
CHICAGO, IL, 60621

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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 <b>Leenie d Stpeter</b>	2 Social security number (SSN) *****4615	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>31 Lexington St</b>	4 City or town <b>CHICAGO IL</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province <b>IL</b>	6 County and ZIP or foreign postal code <b>60621</b>	11 City or town <b>GREENVILLE SC</b>	12 State or province <b>SC</b>
13 Country and ZIP or foreign postal code <b>29607</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Leenie d Stpeter	*****4615	02-22-1993	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Mary d Stpeter	*****4163	06-18-1976	<input checked="" 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)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Roxanna x Maio  
5 East Carriage Street  
RICHMOND, VA, 23223

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- 1A.** Minimum 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 Roxanna X Maio	2 Social security number (SSN) *****0294	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 5 East Carriage Street	4 City or town RICHMOND	5 State or province VA	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code 23223	11 City or town GREENVILLE	12 State or province SC	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code 29607			

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

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

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

(a) Name of covered individual(s)	(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 Roxanna x Maio	*****0294	03-28-1990	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Chris w Maio	*****7982	01-04-1988	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Ghislaine c Dahle  
10 Pierce Street  
WESTBURY, NY, 11590

## 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

**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 Ghislaine c Dahle	2 Social security number (SSN) *****0475	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 10 Pierce Street	4 City or town WESTBURY	5 State or province NY	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 11590	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC
		13 Country and ZIP or foreign postal code 29607	

**Applicable Large Employer Member (Employer)**

14 Offer of Coverage (enter required code) 1A	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) 2C												

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 04												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Ghislaine c Dahle	*****0475	10-09-1987	<input checked="" type="checkbox"/>	<input type="checkbox"/>										
18 Rebeca g Dahle	*****4629	11-16-1970	<input checked="" 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

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Laurinda d Markus  
8732 Helen Street  
WILMINGTON, MA, 01887

## Instructions for Recipient

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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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 Laurinda d Markus	2 Social security number (SSN) *****8402	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 8732 Helen Street		9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
4 City or town WILMINGTON	5 State or province MA	11 City or town GREENVILLE	12 State or province SC
	6 County and ZIP or foreign postal code 01887		13 Country and ZIP or foreign postal code 29607

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A												
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
17 Laurinda d Markus	*****8402	08-20-1968	<input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18 Regenia b Markus	*****8330	09-27-1984	<input checked="" 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"/>

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Orville c Carns  
333 Bowman Street  
NICEVILLE, FL, 32578

## 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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 Orville C Carns	2 Social security number (SSN) *****5105	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 333 Bowman Street	4 City or town NICEVILLE	5 State or province FL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
		6 County and ZIP or foreign postal code 32578	10 Contact telephone number 5555655555
		11 City or town GREENVILLE	12 State or province SC

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1A													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Orville c Carns	*****5105	04-04-1969	X	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Leonie g Carns	*****4830	10-02-1966	X	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Ivan c Grable  
180 Blue Spring Street  
GRAYSLAKE, IL, 60030

## Instructions for Recipient

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

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

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

**1A.** Minimum 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 Ivan C Grable	2 Social security number (SSN) *****8387	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) 180 Blue Spring Street	4 City or town GRAYSLAKE IL	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A	10 Contact telephone number 5555655555
5 State or province IL	6 County and ZIP or foreign postal code 60030	11 City or town GREENVILLE SC	12 State or province SC
13 Country and ZIP or foreign postal code 29607			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 04											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Ivan c Grable	*****8387	01-04-1988	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Rodger t Grable	*****2538	07-15-1981	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

Brian's Testing Company 1  
18 Interchange Blvd Suite A  
GREENVILLE, SC, 29607

Lea t Castille  
156 Garden Lane  
WOODSTOCK, GA, 30188

## 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.

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

## 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 <b>Leat Castille</b>	2 Social security number (SSN) *****7887	7 Name of employer Brian's Testing Company 1	8 Employer identification number (EIN) 55-5515555
3 Street address (including apartment no.) <b>156 Garden Lane</b>	4 City or town <b>WOODSTOCK</b>	5 State or province <b>GA</b>	9 Street address (including room or suite no.) 18 Interchange Blvd Suite A
6 County and ZIP or foreign postal code <b>30188</b>	11 City or town <b>GREENVILLE</b>	12 State or province <b>SC</b>	10 Contact telephone number 5555655555
13 Country and ZIP or foreign postal code <b>29607</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 04												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

### Part III Covered Individuals

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 Leat Castille	*****7887	01-15-1987	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18 Florinda d Castille	*****2258	06-02-1977	<input checked="" type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
19			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
20			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
21			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
22			<input type="checkbox"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

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

Cat. No. 60705M

Form 1095-C (2016)