

LIONEL LENOIR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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 LIONEL LENOIR	2 Social security number (SSN) *****0988	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdfasd ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

COLBY PERRY  
1 Main St  
GREER, RI, 12351

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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 COLBY PERRY	2 Social security number (SSN) *****9558	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

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

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

PRASHANTH PITTAL  
1 Main St  
GREER, RI, 12351

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- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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

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

### Part I Employee

1 Name of employee <b>PRASHANTH PITTAL</b>	2 Social security number (SSN) *****8745	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>	13 Country and ZIP or foreign postal code <b>23423</b>		

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

ERIC LINDEBLAD  
1 Main St  
GREER, RI, 12351

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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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**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 I Employee**

1 Name of employee ERIC LINDEBLAD	2 Social security number (SSN) *****3423	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	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"/> 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			<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
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.

VICTOR TEJEDA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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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JANINA WRIGHT  
1 Main St  
GREER, RI, 12351

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

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

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

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

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

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

that your employer has 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.

**Part I Employee**

1 Name of employee <b>JANINA WRIGHT</b>	2 Social security number (SSN) *****8732	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>		
	Jan	Feb	Mar
	Apr	May	June
	July	Aug	Sept
	Oct	Nov	Dec

**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) <b>1E</b>												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

CHRISTOPHER BAILEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

### Part I. Employee.

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

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

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

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

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

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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

**Part I Employee**  
 Name of employee  
 CHRISTOPHER BAILEY  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

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

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

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

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

VAUGHN BARKHURST  
1 Main St  
GREER, RI, 12351

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

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

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

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**Part I Employee**  
 Name of employee  
 VAUGHN BARKHURST  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****7395	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JEANNIE HII  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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 JEANNIE HILL	2 Social security number (SSN) *****7731	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Applicable Large Employer Member (Employer)**

		Plan Start Month (Enter 2-digit number): 11											
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months	1H	1H	1H	1H	1H	1E	1E	1E	1H	1H	1H	1H	1H
14 Offer of Coverage (enter required code)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2G	2G	2B	2B	2A	2A	2A

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H	1H	1H	1H	1H	1H	1E	1E	1E	1H	1H	1H	1H
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2A	2A	2A	2A	2A	2A	2D	2G	2G	2B	2B	2A	2A

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

DARIN TAKAKI  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 DARIN TAKAKI  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

 VOID

 CORRECTED

DOUGLAS LEBLANC  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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

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

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

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



MATTHEW ANDERSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>MATTHEW ANDERSON</b>	2 Social security number (SSN) *****4027	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	

### Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

JASON ZERO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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.



TRICIA ROEHRENBECK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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 TRICIA ROETHRENBECK	2 Social security number (SSN) *****0266	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

ROBERT CASHMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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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### 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>ROBERT CASHMAN</b>	2 Social security number (SSN) *****4833	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
<b>2G</b>													

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

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

WILL REAGAN  
1 Main St  
GREER, RI, 12351

## 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).

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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.

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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  
**WILL REAGAN**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

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

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****3490		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

ADAM SCOTT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

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

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

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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

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

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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 ADAM SCOTT	2 Social security number (SSN) *****5595	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

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

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

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

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

2016

SU KIM  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

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

**Part I Employee**  
 1 Name of employee  
 SU KIM  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**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**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G
17													
18													
19													
20													
21													
22													

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****8029	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	12351

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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				
18				
19				
20				
21				
22				

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

Cat. No. 60705M

BRUCE SHAW  
1 Main St  
GREER, RI, 12351

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

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

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

**Part I Employee**  
 1 Name of employee  
 BRUCE SHAW  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												
<b>Plan Start Month (Enter 2-digit number): 11</b>													

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

 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)**
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****6856	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	12351
AJO		AZ	AJO

(e) Months of Coverage

JESSE GRAHAM  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>JESSE GRAHAM</b>	2 Social security number (SSN) *****0986	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

TAYLOR FORBES  
1 Main St  
GREER, RI, 12351

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

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

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

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



CLINT LUDER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

**Part I Employee**  
 1 Name of employee  
 CLINT LUDER  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E	1E	1E	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
17													
18													
19													
20													
21													
22													

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****0826	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	12351

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(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				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18				
19				
20				
21				
22				

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

Cat. No. 60705M

Form 1095-C (2016)

JEFFREY EVANS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>JEFFREY EVANS</b>	2 Social security number (SSN) *****0110	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

MARK TOMASSI  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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  
 MARK TOMASSI  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)

<b>Applicable Large Employer Member (Employer)</b>												
1 Name of employer MARK TOMASSI	2 Social security number (SSN) *****1216	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) 1 Main St	9 Street address (including room or suite no.) Safdfasd ADFA	10 Contact telephone number 2342342342	11 City or town AJO									
4 City or town GREER RI	6 County and ZIP or foreign postal code 12351	12 State or province AZ	13 Country and ZIP or foreign postal code 23423									
<b>Part II Employee Offer of Coverage</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

 Form **1095-C** (2016)

MATTHEW AGORIIWE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>MATTHEW AGORIWE</b>	2 Social security number (SSN) *****8225	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>15 Employee Required Contribution (see instructions)</b> \$ 811.00	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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

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

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

Cat. No. 60705M

MARTI JOHNSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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 <b>MARTI JOHNSON</b>	2 Social security number (SSN) *****0993	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

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

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

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

VOID       CORRECTED

**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

BARRY KLASSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>BARRY KLASSON</b>	2 Social security number (SSN) *****8817	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
<b>14 Offer of Coverage (enter required code)</b>												
<b>15 Employee Contribution (see instructions)</b>												
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2C</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
<b>14 Offer of Coverage (enter required code)</b>												
<b>15 Employee Contribution (see instructions)</b>												
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2C</b>												

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

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

RAYMOND DAVIS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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

**Part I Employee**  
 Name of employee  
 RAYMOND DAVIS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	All 12 Months	Plan Start Month (Enter 2-digit number): 11										
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1E												
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

BENNY GARDUNO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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  
 BENNY GARDUNO  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

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

 ▶ Do not 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)

<input type="checkbox"/> VOID	<input type="checkbox"/> CORRECTED
OMB No. 1545-2251	2016

<b>Applicable Large Employer Member (Employer)</b>	
1 Name of employer	2 Social security number (SSN) *****80900
3 Street address (including apartment no.)	7 Name of employer RMLS
4 City or town	9 Street address (including room or suite no.) Safdasdf ADFA
5 State or province	10 Contact telephone number 2342342342
GREER RI	11 City or town AJJO
12 State or province AZ	13 Country and ZIP or foreign postal code 23423

MICHAEL MELTON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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 <b>MICHAEL MELTON</b>	2 Social security number (SSN) *****5911	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

JESUS GAMA  
1 Main St  
GREER, RI, 12351

## 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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**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.

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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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**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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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RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

EDGARDO SANTIAGO Jr  
1 Main St  
GREER, RI, 12351

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RMS  
sadfasdf ADFA  
AJO, AZ, 23423

JERRY LEE  
1 Main St  
GREER, RI, 12351

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- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**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 JERRY LEE	2 Social security number (SSN) *****9182	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

 Form **1095-C** (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JOSEPH LIEBSCH  
1 Main St  
GREER, RI, 12351

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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.

**Part I Employee**

1 Name of employee <b>JOSEPH LIEBSCH</b>	2 Social security number (SSN) *****1232	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

DAVON WHITE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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**  
 Name of employee  
 DAVON WHITE  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**

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

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

 VOID

 CORRECTED

ALEXIS GUILLERMO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

**Part I Employee**  
 1 Name of employee  
 ALEXIS GUILLERMO  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

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

**Part II Employee Offer of Coverage**

Employee		Applicable Large Employer Member (Employer)																						
1 Name of employee	2 Social security number (SSN) *****8501	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222																					
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code	9 Street address (including room or suite no.)	10 Contact telephone number 2342342342	11 City or town	12 State or province	13 Country and ZIP or foreign postal code	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)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1 Main St	GREER	RI	12351	Sacfasdf ADFA	AJO	AJO	AZ	23423	1E	\$ 811.00	\$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 49.50	11												
									2G															

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.		X											
(a) Name of covered individual(s)	(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				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec									
18													
19													
20													
21													
22													

**For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.**
 VOID       CORRECTED       OMB No. 1545-2251

**2016**

RICHARDSON LOUSSAINT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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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 RICHARDSON LOUSSIANT	2 Social security number (SSN) *****7665	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

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

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

DAVID KLANG  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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  
 DAVID KLANG  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

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

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****28862		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 State or province AZ	Plan Start Month (Enter 2-digit number): 11	
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
14 Offer of Coverage (enter required code) 1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G							

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DONNA BREWER  
1 Main St  
GREER, RI, 12351

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### 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.

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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.

**Part I Employee**

1 Name of employee <b>DONNA BREWER</b>	2 Social security number (SSN) *****9687	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable) 2G		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	2C

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

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

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

 VOID CORRECTED

OMB No. 1545-2251

**2016**

Cat. No. 60705M

Form **1095-C** (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

MICHAEL HARDY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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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>MICHAEL HARDY</b>	2 Social security number (SSN) *****8337	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): <b>11</b>													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>											
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2B</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>							

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

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

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Cat. No. 60705M

 VOID CORRECTEDOMB No. 1545-2251  
**2016**Form **1095-C** (2016)

GOPIKRISHNA PODILI  
1 Main St  
GREER, RI, 12351

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

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

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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

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

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

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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
**GOPIKRISHNA PODILLI**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

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

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

DANIEL JONES  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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 continue Part III.

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

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

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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.  
**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>DANIEL JONES</b>	2 Social security number (SSN) *****1034	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>									

**Part III Covered Individuals**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is 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"/>	

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

LIANA VO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Part I Employee**  
 1 Name of employee  
 LIANA VO  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

▶ Do not 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) *****1819	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
4 City or town GREER RI	5 State or province 12351	6 County and ZIP or foreign postal code AJO	

**Part III Covered Individuals**

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

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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

BRENDAN SHUMBERGER  
1 Main St  
GREER, RI, 12351

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

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

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

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

**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 BRENDAN SHUMBERGER	2 Social security number (SSN) *****0402	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

BRYAN SMETHERS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>BRYAN SMEOTHERS</b>	2 Social security number (SSN) *****2055	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222																																																																													
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO AZ</b>																																																																													
<b>Applicable Large Employer Member (Employer)</b>																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="12" style="text-align: left; padding-bottom: 5px;">Plan Start Month (Enter 2-digit number): <b>11</b></th> </tr> <tr> <th>All 12 Months</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>June</th> <th>July</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> </tr> </thead> <tbody> <tr> <td><b>1E</b></td> <td></td> </tr> <tr> <td><b>\$</b></td> <td><b>\$ 811.00</b></td> <td><b>\$ 49.50</b></td> </tr> <tr> <td><b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b></td> <td></td> </tr> <tr> <td><b>2G</b></td> <td></td> </tr> </tbody> </table>				Plan Start Month (Enter 2-digit number): <b>11</b>												All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	<b>1E</b>													<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													<b>2G</b>																						
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### Part II Employee Offer of Coverage

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)
<b>1E</b>	<b>\$ 811.00</b>	<b>2G</b>

### Part III Covered Individuals

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

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

WILLIE RICHARDSONJr  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

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

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

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

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

**Part I Employee**  
 Name of employee  
 WILLIE RICHARDSONJR  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D

**Part III Covered Individuals**

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

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

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

CARLOS VERAS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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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KEITH SARGENT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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 KEITH SARGENT	2 Social security number (SSN) *****5455	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

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

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

 VOID CORRECTED**Applicable Large Employer Member (Employer)**

8 Employer identification number (EIN) 23-4232222	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423	11 City or town AJJO	12 State or province AZ

ALNISA BURWELL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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 <b>ALNISA BURWELL</b>	2 Social security number (SSN) *****5836	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E	1E	1E	1E	1E	1H							
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
<b>14 Offer of Coverage (enter required code)</b>	<b>15 Employee Required Contribution (see instructions)</b>	<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>
2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
<b>Part II Employee Offer of Coverage</b>	<b>Plan Start Month (Enter 2-digit number): 11</b>											

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is 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"/>
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"/>
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"/>
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"/>
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"/>
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"/>

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

Cat. No. 60705M

Form **1095-C** (2016)

ANDREW MILLER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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

**Part I Employee**  
 Name of employee  
 ANDREW MILLER  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

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

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

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

STUART OSTERWEIL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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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### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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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 <b>STUART OSTERWEIL</b>	2 Social security number (SSN) *****41122	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months												
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> \$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
\$ <b>811.00</b>												
<b>2G</b>												

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

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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

CLAY OELZEN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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  
 CLAY OELZEN  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

▶ Do not 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)**

<input type="checkbox"/> VOID	<input type="checkbox"/> CORRECTED
OMB No. 1545-2251	2016

STEVEN KRAKOWER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>STEVEN KRAKOWER</b>	2 Social security number (SSN) *****6612	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

AARON COLON  
1 Main St  
GREER, RI, 12351

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

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

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

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

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

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

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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.  
**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 AARON COLON	2 Social security number (SSN) *****1586	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

DELVIN SMITH  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**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)**

1 Name of employee DELVIN SMITH	2 Social security number (SSN) *****1529	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code)		
	All 12 Months	Jan	Feb
	1E	1E	1E
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B
	2A	2A	2A
	2A	2A	2A
	2A	2A	2A

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

**Part III Covered Individuals**

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

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

JOSE ALOMIA  
1 Main St  
GREER, RI, 12351

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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  
**JOSE ALOMIA**  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

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

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	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)	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2B	2B	2A

**Part III Covered Individuals**

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

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

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

RAMESH ARREPU  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

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

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

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

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

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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>RAMESH ARREPU</b>	2 Social security number (SSN) *****3663	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

### Part III Covered Individuals

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

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

DAVID ARNEMANN  
1 Main St  
GREER, RI, 12351

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

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

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

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 <b>DAVID ARNEMANN</b>	2 Social security number (SSN) *****2286	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>										
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>										
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>													

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

### Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

TRINA CARSTENS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

- 1A.** Minimum 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 <b>TRINA CARSTENS</b>	2 Social security number (SSN) *****9087	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

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

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

 VOID CORRECTED

OMB No. 1545-2251

**2016**Form **1095-C** (2016)

Cat. No. 60705M

AINKA BLACKMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>AINKA BLACKMAN</b>	2 Social security number (SSN) *****1166	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): <b>11</b>											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1E</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>	<b>1H</b>
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$</b>						
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2B</b>	<b>2B</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>

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

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

JEMELL WHITE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part I. Employee.

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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



CHRIS LORSAN  
1 Main St  
GREER, RI, 12351

## 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

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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>CHRIS LORSAN</b>	2 Social security number (SSN) *****5960	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

SEAN CONRAD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 SEAN CONRAD  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)

<b>Applicable Large Employer Member (Employer)</b>															
1 Name of employer	2 Social security number (SSN) *****0511	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222												
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA			10 Contact telephone number 2342342342											
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423										
<b>Part II Employee Offer of Coverage</b>													Plan Start Month (Enter 2-digit number): 11		
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
1E															
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G														
<b>Part III Covered Individuals</b>													If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>		
(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Cat. No. 60705M

 Form **1095-C** (2016)

MARGARET GUSSE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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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>MARGARET GUSSIE</b>	2 Social security number (SSN) *****6756	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

JUN CHEN  
1 Main St  
GREER, RI, 12351

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

**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)**

1 Name of employee JUN CHEN	2 Social security number (SSN) *****5948	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

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

**Part III Covered Individuals**

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

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

JOSE DELGADO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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**  
 Name of employee  
**JOSE DELGADO**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**  
 County and ZIP or foreign postal code  
**AJO**
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****5818	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	12351	11 City or town AJO
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**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)	1E	1E	1E	1E	1E	1E	1H						
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
17													
18													
19													
20													
21													
22													

**Part III Covered Individuals**

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

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

Cat. No. 60705M

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JAYONNA KING  
1 Main St  
GREER, RI, 12351

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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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ALEKSANDR VASILYEV  
1 Main St  
GREER, RI, 12351

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

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

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

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

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

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

**Part I Employee**  
 Name of employee  
 ALEKSANDR VASIL'YEV  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****8296	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA											
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342									
GREER	RI	11 City or town AZ	12 State or province AZ									
13 Country and ZIP or foreign postal code 23423												
<b>Plan Start Month</b> (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	1E	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

CHARLES MILLS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 CHARLES MILLS  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

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

▶ Do not 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) *****0440	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	13 Country and ZIP or foreign postal code AZ 23423
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	12 State or province AZ

Plan Start Month (Enter 2-digit number): 11													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**

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

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

JUSTIN ROSADO  
1 Main St  
GREER, RI, 12351

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

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

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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>JUSTIN ROSADO</b>	2 Social security number (SSN) *****1987	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

## Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

## Part III Covered Individuals

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

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

SHELLEY STEPHENS  
1 Main St  
GREER, RI, 12351

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

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

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

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

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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
**SHELLEY STEPHENS**  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not attach to your tax return. Keep for your records.

 VOID       CORRECTED

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****0485		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI		5 State or province 12351	6 County and ZIP or foreign postal code AJO									
9 Street address (including room or suite no.) Safdasdf ADFA	11 City or town AJO		12 State or province AZ	13 Country and ZIP or foreign postal code 23423									
<b>Plan Start Month</b> (Enter 2-digit number): 11													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
15 Employee Required Contribution (see instructions) 2G													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**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) 1E	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
15 Employee Required Contribution (see instructions) 2G													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

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(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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"/>
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

ELIZABETH AMES  
1 Main St  
GREER, RI, 12351

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

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

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

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**Part I Employee**  
 1 Name of employee  
**ELIZABETH AMES**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

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

**Employee**

1 Name of employee	2 Social security number (SSN) *****0492		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)  1 Main St	4 City or town GREER RI		5 State or province 12351	6 County and ZIP or foreign postal code AJO
9 Street address (including room or suite no.)  Safdasdf ADFA	10 Contact telephone number 2342342342		11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423				

**Applicable Large Employer Member (Employer)**

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

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1H									
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

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

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

POORNIMA JAYAPALAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Part I Employee**  
 Name of employee  
 POORNIMA JAYAPALAN  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****3065	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
12 State or province AZ	13 Country and ZIP or foreign postal code 23423		

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

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

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

BRIAN GANTT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>BRIAN GANTT</b>	2 Social security number (SSN) *****4527	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

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

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

VOID

CORRECTED

ROBERT HECKMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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

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

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

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

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

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

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

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

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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>ROBERT HECKMAN</b>	2 Social security number (SSN) *****7464	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO AZ</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>			
10 Contact telephone number <b>2342342342</b>		11 City or town <b>AJO</b>	
12 State or province <b>AZ</b>		13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): <b>11</b>										
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

JASON BARKHURST  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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 JASON BARKHURST	2 Social security number (SSN) *****3546	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

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

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

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

VOID  
 CORRECTED

OMB No. 1545-2251  
2016

KERRIANN ROOMES  
1 Main St  
GREER, RI, 12351

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

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

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

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

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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      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 <b>KERRIANN ROOMES</b>	2 Social security number (SSN) *****2386	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1H							
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A

**Part II Employee Offer of Coverage**

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

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

SCOTT STEELE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

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

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

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

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

**Part I Employee**  
 1 Name of employee  
 SCOTT STEELE  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

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

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

**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)**
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****4167	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER RI	12351	AJO AZ

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

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

UTSAV BHARDWAJ  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

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

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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**  
 Name of employee  
 UTSAV BHARDWAJ  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E	Plan Start Month (Enter 2-digit number): 11												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G													

**Part III Covered Individuals**

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

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

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

Cat. No. 60705M

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

MARLA STEWARD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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>MARLA STEWARD</b>	2 Social security number (SSN) *****4519	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

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

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

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

 VOID CORRECTED

OMB No. 1545-2251

**2016**Form **1095-C** (2016)

Cat. No. 60705M

ELIZABETH TRIMBLE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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

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

### Part I. Employee.

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

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

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

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

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

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

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

**1A.** Minimum 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 <b>ELIZABETH TRIMBLE</b>	2 Social security number (SSN) *****0616	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

WILLIAM ANDERSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

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

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

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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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>WILLIAM ANDERSON</b>	2 Social security number (SSN) *****7458	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months <b>1E</b>												
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

**Part II Employee Offer of Coverage**

All 12 Months <b>1E</b>	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

PETERSON PHE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 PETERSON PHE  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****0550		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
9 Street address (including room or suite no.) Safdasdf ADFA							
10 Contact telephone number 2342342342		11 City or town AJO		12 State or province AZ		13 Country and ZIP or foreign postal code 23423	
<b>Plan Start Month</b> (Enter 2-digit number): 11							
14 Offer of coverage (enter required code) 1E		Jan		Feb		March	
15 Employee Required Contribution (see instructions) \$ 811.00		\$ 811.00		\$ 811.00		\$ 811.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)		(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									
18									
19									
20									
21									
22									

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JOHN CARUTHERS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>JOHN CARUTHERS</b>	2 Social security number (SSN) *****1142	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342											
11 Plan Start Month (Enter 2-digit number): <b>11</b>	12											
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E	1E	1E	1E	1H								
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A						

**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)	1E	1E	1E	1H								
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A						

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

BRITTANY PRESSEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part 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 BRITTANY PRESSEY	2 Social security number (SSN) *****9247	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	Plan Start Month (Enter 2-digit number): 11												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E	\$ 811.00	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H
							\$	\$	\$	\$	\$	\$	\$	\$
2G	2G	2G	2G	2G	2G	2G	2B	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

TIFFANY PRINGLE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 TIFFANY PRINGLE  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****3196		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI		5 State or province 12351	6 County and ZIP or foreign postal code AJJO
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342		11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423				

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

KIMGENE NGUYEN  
1 Main St  
GREER, RI, 12351

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- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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 <b>KIMGENE NGUYEN</b>	2 Social security number (SSN) *****5147	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> <b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
<b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

ROBBIE WEISS  
1 Main St  
GREER, RI, 12351

## 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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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
**ROBBIE WEISS**  
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**Employer-Provided Health Insurance Offer and Coverage**

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**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****2915		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222			
		5 State or province RI		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342			
		6 County and ZIP or foreign postal code 12351		11 City or town AJO		12 State or province AZ			
<b>Part III Covered Individuals</b>									
		If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>							
(a) Name of covered individual(s)		(b) SSN or other TIN		(c) DOB (If SSN or other TIN is not available)		(d) Covered all 12 months			
17				<input type="checkbox"/>		<input type="checkbox"/>			
18				<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"/>			

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Cat. No. 60705M

 Form **1095-C** (2016)

RYAN ESTOK  
1 Main St  
GREER, RI, 12351

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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

**Part I Employee**  
 1 Name of employee  
 RYAN ESTOK  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****0926	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	11 City or town AZ
		12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**Part III Covered Individuals**

Plan Start Month (Enter 2-digit number): 11													
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)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	2G

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(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)

WANDA BELL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 WANDA BELL  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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)	1H	1H	1H	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2D	2G	2G	2G	2G	2G	2G	2G	2B
17													
18													
19													
20													
21													
22													

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
22															

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**
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****47444	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	AJO

**Plan Start Month (Enter 2-digit number): 11**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2D	2G	2G	2G	2G	2G	2G	2G	2B
17													
18													
19													
20													
21													
22													

X

(e) Months of Coverage

DAVID PIVARAL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 DAVID PIVARAL	2 Social security number (SSN) *****2776	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	1E	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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"/>

JEFFREY RUTHERFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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 JEFFREY RUTHERFORD	2 Social security number (SSN) *****3181	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

LABREDA CONNER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 <b>LABREDA CONNER</b>	2 Social security number (SSN) *****7758	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1H</b>												
<b>15 Employee Contribution (see instructions)</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	2A	2D	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): <b>11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1H</b>												
<b>15 Employee Contribution (see instructions)</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	2A	2D	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<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)

ERIC SPAGNOLI  
1 Main St  
GREER, RI, 12351

## 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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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** 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

**Part I Employee**  
 1 Name of employee  
 ERIC SPAGNOLI  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****4524	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342										
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423									
4 City or town	5 State or province RI	6 County and ZIP or foreign postal code 12351										
<b>Plan Start Month</b> (Enter 2-digit number): 11												
14 Offer of Coverage (enter required code)	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****4524	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423

 VOID

 CORRECTED

**2016**

OMB No. 1545-2251

MEGAN PRESTON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>MEGAN PRESTON</b>	2 Social security number (SSN) *****3002	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Form 1095-C (2016)

GOKHAN KARAKUS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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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 III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
**GOKHAN KARAKUS**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	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)	2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JUSTIN SISKEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>JUSTIN SISKEY</b>	2 Social security number (SSN) *****81155	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
Safdasdf ADFA	AJO	11 City or town <b>AZ</b>	12 State or province <b>AZ</b>
			13 Country and ZIP or foreign postal code <b>23423</b>

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

DANECIA HAMPTON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>DANECA HAMPTON</b>	2 Social security number (SSN) *****5938	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	9 Street address (including room or suite no.) <b>Sadfasdf ADFA</b>	8 Employer identification number (EIN) 23-4232222
4 City or town <b>GREER</b>	5 State or province <b>RI</b>	10 Contact telephone number 2342342342
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>		

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

LUIS MERCED  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 LUIS MERCED  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)

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		OMB No. 1545-2251																																																									
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<b>Applicable Large Employer Member (Employer)</b>																																																											
<b>1</b> Name of employee LUIS MERCED		<b>2</b> Social security number (SSN) *****8603																																																									
<b>3</b> Street address (including room or suite no.) 1 Main St		<b>7</b> Name of employer RM/S																																																									
<b>4</b> City or town GREER RI		<b>5</b> State or province 12351																																																									
<b>6</b> County and ZIP or foreign postal code AJO		<b>8</b> Employer identification number (EIN) 23-4232222																																																									
<b>9</b> Street address (including room or suite no.) Sacfasdf ADFA		<b>10</b> Contact telephone number 2342342342																																																									
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<b>Part II Employee Offer of Coverage</b>																																																											
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MARIA JAVIER  
1 Main St  
GREER, RI, 12351

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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

 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 <b>MARIA JAVIER</b>	2 Social security number (SSN) *****0218	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

PETER SOKOLIK  
1 Main St  
GREER, RI, 12351

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 Form  
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 PETER SOKOLIK  
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**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****1748		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
9 Street address (including room or suite no.) Safdasdf ADFA							
10 Contact telephone number 2342342342		11 City or town AJO		12 State or province AZ		13 Country and ZIP or foreign postal code 23423	
<b>Plan Start Month</b> (Enter 2-digit number): 11							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E	1E	1E	1E	1E	1E	1E	1E
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G
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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

TERRY CURTIS  
1 Main St  
GREER, RI, 12351

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**Part I Employee**

1 Name of employee <b>TERRY CURTIS</b>	2 Social security number (SSN) *****3844	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

<b>Part II Employee Offer of Coverage</b>		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

ARTEM MASLYUK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 ARTEM MASLYUK	2 Social security number (SSN) *****9935	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

## Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2A	2A								

## Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DEWAINE COBB  
1 Main St  
GREER, RI, 12351

## 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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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
**DEWAINE COBB**  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****2969		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ		
<b>Part II Employee Offer of Coverage</b>							
14 Offer of coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

FERNANDO GOMEZEVELSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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### Part II. Employer Offer and Coverage, Lines 14-16.

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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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### 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)**
**Applicable Large Employer Member (Employer)**

1 Name of employee FERNANDO GOMEZEVELSON	2 Social security number (SSN) *****0541	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO
4 City or town GREER RI	6 County and ZIP or foreign postal code 12351	12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**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) 1E												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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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

CHABLIS BRADY  
1 Main St  
GREER, RI, 12351

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



DANIEL KIM  
1 Main St  
GREER, RI, 12351

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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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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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**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>DANIEL KIM</b>	2 Social security number (SSN) *****4817	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E	1H	1H	1H								
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A								

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

ZHIEN LI  
1 Main St  
GREER, RI, 12351

## 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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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

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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 ZHIEN LI	2 Social security number (SSN) *****8911	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code)		
	All 12 Months	Jan	Feb
	1E	1E	1E
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2G	2G	2G
	2G	2G	2G
	2A	2A	2A
	2A	2A	2A
	2A	2A	2A

**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)	1E	1E	1E	1E	1E	1H							
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A
	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

LISA LONGCHAMPS  
1 Main St  
GREER, RI, 12351

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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>LISA LONGCHAMPS</b>	2 Social security number (SSN) *****5458	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): <b>11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
<b>15 Employee Contribution (see instructions)</b>	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2C	2C

**Part II Employee Offer of Coverage**

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.  VOID CORRECTEDOMB No. 1545-2251  
**2016**

AARON ELDRIDGE  
1 Main St  
GREER, RI, 12351

## 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).

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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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DAVID MALLORY  
1 Main St  
GREER, RI, 12351

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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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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 DAVID MALLORY  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****88888		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdfasd ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JOSE LINARES  
1 Main St  
GREER, RI, 12351

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**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.

1 Name of employee JOSE LINARES	2 Social security number (SSN) *****1576	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Sacfasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

FRANCIS HESKETH  
1 Main St  
GREER, RI, 12351

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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	2 Social security number (SSN) *****5261		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
FRANCIS HESKEETH			9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
3 Street address (including apartment no.)			11 City or town AJO	13 Country and ZIP or foreign postal code AZ 23423
1 Main St	5 State or province RI	6 County and ZIP or foreign postal code 12351	12 State or province AZ	

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
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"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

2016

Form 1095-C (2016)

REBECCA TAYLOR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>REBECCA TAYLOR</b>	2 Social security number (SSN) *****0085	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED

OMB No. 1545-2251

**2016**

Cat. No. 60705M

Form **1095-C** (2016)

MAYRA KRAUSE  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
**MAYRA KRAUSE**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

SIMONE GAYLE  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 SIMONE GAYLE  
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**Employer-Provided Health Insurance Offer and Coverage**

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**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
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17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED

OMB No. 1545-2251

**2016**

SRINIVAS TATAPUDI  
1 Main St  
GREER, RI, 12351

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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>SRINIVAS TATAPUDI</b>	2 Social security number (SSN) *****9855	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months <b>1E</b>												
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

**Part II Employee Offer of Coverage**

All 12 Months <b>1E</b>	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

TIARA MASTERS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 Name of employee  
 TIARA MASTERS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1H												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2B	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

	(a) Name of covered individual(s)	(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"/>

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

8	Employer identification number (EIN) RMLS	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
---	--	---	---	------------------------	----------------------------	--

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DENISE GOMER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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>DENISE GOMER</b>	2 Social security number (SSN) *****9095	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

Applicable Large Employer Member (Employer)												
Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 49.50</b>												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>												

**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) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 49.50</b>												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>												

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17											
18											
19											
20											
21											
22											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

DIANA BITLER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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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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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 DIANA BITLER  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****3717	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

JOHN GALAZIN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 ▶ Do not 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)**
**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 II Employee Offer of Coverage**

		Applicable Large Employer Member (Employer)											
1 Name of employee		2 Social security number (SSN) *****4436		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222							
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342			
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E													
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

ANGELEC GLOVER  
1 Main St  
GREER, RI, 12351

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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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### Part II. Employer Offer and Coverage, Lines 14-16.

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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>ANGELIEC GLOVER</b>	2 Social security number (SSN) *****3708	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	9 Street address (including room or suite no.) <b>Sadfasdf ADFA</b>	8 Employer identification number (EIN) 23-4232222
4 City or town <b>GREER RI</b>	6 County and ZIP or foreign postal code <b>12351</b>	10 Contact telephone number 2342342342
5 State or province <b>RI</b>	11 City or town <b>AJO</b>	13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	All 12 Months	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JOSHUA KAPLAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has 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>JOSHUA KAPLAN</b>	2 Social security number (SSN) *****5794	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1H									
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2A									

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Cat. No. 60705M

Form 1095-C (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

OTTO DUNN  
1 Main St  
GREER, RI, 12351

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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.



DATIKKA WRIGHT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 DATIKKA WRIGHT  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****7924	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	AJO 12351

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(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)

ALICE DOTSON  
1 Main St  
GREER, RI, 12351

## 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

## 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>ALICE DOTSON</b>	2 Social security number (SSN) *****0612	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

DESIREE TURNER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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>DESIREE TURNER</b>	2 Social security number (SSN) *****6476	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
AJJO	AJO	AZ	AZ

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

DONNIE JONES  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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  
 DONNIE JONES  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E	1E	1E	1H									
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****7204	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER RI	12351	AJO AZ

**Plan Start Month (Enter 2-digit number):** 11

ALEKSANDR SEDLIN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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

**Part I Employee**  
 Name of employee  
**ALEKSANDR SEDLIN**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**  
 County and ZIP or foreign postal code  
**AJO AZ**
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****9465	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	12351	11 City or town AJO
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**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)	1H												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

ALDEN WEGE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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.  
**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 ALDEN WEGE	2 Social security number (SSN) *****6109	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

JESSICA BALL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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.
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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



BRANDON MEDEIROS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>BRANDON MEDEIROS</b>	2 Social security number (SSN) *****8157	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H													
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID CORRECTED**2016**

ASHTON HOBELMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>ASHTON HOBELMAN</b>	2 Social security number (SSN) *****7509	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
	<b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID CORRECTEDOMB No. 1545-2251  
**2016**Form **1095-C** (2016)

PAUL APONTE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 PAUL APONTE  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

 VOID

 CORRECTED

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DAVID MAQUILON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

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**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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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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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 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	2 Social security number (SSN) *****7907			7 Name of employer RMLS	8 Employer identification number (EIN)
DAVID MAQUILLON				Safdasdf ADFA	23-4232222
3 Street address (including apartment no.)				9 Street address (including room or suite no.)	10 Contact telephone number 2342342342
1 Main St				11 City or town AJO	13 Country and ZIP or foreign postal code AZ
4 City or town	5 State or province	6 County and ZIP or foreign postal code 12351			14 Plan Start Month (Enter 2-digit number): 11
GREER	RI				All 12 Months
		Jan	Feb	Mar	April
		1E	1E	1E	May
				1E	June
				1E	July
				1E	Aug
				1E	Sept
				1E	Oct
				1E	Nov
				1E	Dec

**Part II Employee Offer of Coverage**

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	18	19	20	21	22
All 12 Months	\$ 811.00	2G	All 12 Months					
Jan	\$ 811.00	2G	Jan	Jan	Jan	Jan	Jan	Jan
Feb	\$ 811.00	2G	Feb	Feb	Feb	Feb	Feb	Feb
Mar	\$ 811.00	2G	Mar	Mar	Mar	Mar	Mar	Mar
Apr	\$ 811.00	2G	Apr	Apr	Apr	Apr	Apr	Apr
May	\$ 811.00	2G	May	May	May	May	May	May
June	\$ 811.00	2G	June	June	June	June	June	June
July	\$ 811.00	2G	July	July	July	July	July	July
Aug	\$ 811.00	2G	Aug	Aug	Aug	Aug	Aug	Aug
Sept	\$ 811.00	2G	Sept	Sept	Sept	Sept	Sept	Sept
Oct	\$ 811.00	2G	Oct	Oct	Oct	Oct	Oct	Oct
Nov	\$ 811.00	2G	Nov	Nov	Nov	Nov	Nov	Nov
Dec	\$ 811.00	2G	Dec	Dec	Dec	Dec	Dec	Dec
All 12 Months	\$ 811.00	2G	All 12 Months					
Jan	\$ 811.00	2G	Jan	Jan	Jan	Jan	Jan	Jan
Feb	\$ 811.00	2G	Feb	Feb	Feb	Feb	Feb	Feb
Mar	\$ 811.00	2G	Mar	Mar	Mar	Mar	Mar	Mar
Apr	\$ 811.00	2G	Apr	Apr	Apr	Apr	Apr	Apr
May	\$ 811.00	2G	May	May	May	May	May	May
June	\$ 811.00	2G	June	June	June	June	June	June
July	\$ 811.00	2G	July	July	July	July	July	July
Aug	\$ 811.00	2G	Aug	Aug	Aug	Aug	Aug	Aug
Sept	\$ 811.00	2G	Sept	Sept	Sept	Sept	Sept	Sept
Oct	\$ 811.00	2G	Oct	Oct	Oct	Oct	Oct	Oct
Nov	\$ 811.00	2G	Nov	Nov	Nov	Nov	Nov	Nov
Dec	\$ 811.00	2G	Dec	Dec	Dec	Dec	Dec	Dec

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(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			□	□ June □ July □ Aug □ Sept □ Oct □ Nov □ Dec
18			□	□ June □ July □ Aug □ Sept □ Oct □ Nov □ Dec
19			□	□ June □ July □ Aug □ Sept □ Oct □ Nov □ Dec
20			□	□ June □ July □ Aug □ Sept □ Oct □ Nov □ Dec
21			□	□ June □ July □ Aug □ Sept □ Oct □ Nov □ Dec
22			□	□ 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)

JEFF KNOX  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 JEFF KNOX	2 Social security number (SSN) *****0089	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

BRIAN LUKE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.  
 ▶ 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>BRIAN LUKE</b>	2 Social security number (SSN) *****6120	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COLLIN HELLUM  
1 Main St  
GREER, RI, 12351

## 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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### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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### 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  
**COLLIN HELLUM**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****5827		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16	Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G					

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

SHELBY MILLER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
**SHELBY MILLER**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A								

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

ERIC SELDIN  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 ERIC SELDIN  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****2545	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342										
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423									
4 City or town	5 State or province RI	6 County and ZIP or foreign postal code 12351										
<b>Plan Start Month</b> (Enter 2-digit number): 11												
14 Offer of Coverage (enter required code)	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

STEPHEN HOWARD  
1 Main St  
GREER, RI, 12351

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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>STEPHEN HOWARD</b>	2 Social security number (SSN) *****6014	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
<b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 CORRECTEDOMB No. 1545-2251  
**2016**Form **1095-C** (2016)

GILBERT VALENZUELA  
1 Main St  
GREER, RI, 12351

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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 GILBERT VALENZUELA	2 Social security number (SSN) *****0945	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

ROGER COOK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 ROGER COOK  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****3583		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

DANIEL CRAWFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>DANIEL CRAWFORD</b>	2 Social security number (SSN) *****2091	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

MARK CHRISTOFFERSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)**
**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 II Employee Offer of Coverage**

1 Name of employee <b>MARK CHRISTOFFERSON</b>	2 Social security number (SSN) *****0551	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>

**Part III Covered Individuals**

		Plan Start Month (Enter 2-digit number): 11											
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	All 12 Months												
1E													
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C	

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

		(e) Months of Coverage															
		(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
21					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
22					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

ANGELA BRANDT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>ANGELA BRANDT</b>	2 Social security number (SSN) *****41153	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2G</b>												

**Part II Employee Offer of Coverage**

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>									
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<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)

ASHLEY DIAS  
1 Main St  
GREER, RI, 12351

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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

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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 ASHLEY DIAS	2 Social security number (SSN) *****3799	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
			AJO

### 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)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2D	2G	2G	2G	2C	2C

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17 ASHLEY DIAS	*****3799		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18 KAYDENCE DIAS	*****5549		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

2016

ENRIQUE POSSECOSTAS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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.

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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

**Part I Employee**  
 1 Name of employee  
 ENRIQUE POSSECOSTAS  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****9902	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER	RI	12351
			AJO
			AZ
			11

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(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"/>	Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
18			<input 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)

CRAIG WELSHANS  
1 Main St  
GREER, RI, 12351

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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>CRAIG WELSHANS</b>	2 Social security number (SSN) *****6533	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>	<b>1E</b>												
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
<b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

DOMINIC OTTAVIANO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>DOMINIC OTTAVIANO</b>	2 Social security number (SSN) *****7834	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	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)	2A	2A	2A	2D	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID CORRECTEDOMB No. 1545-2251  
**2016**Form **1095-C** (2016)

ANDREA HAVELIN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>ANDREA HAVELIN</b>	2 Social security number (SSN) *****7662	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>

**Applicable Large Employer Member (Employer)**

8 Employer identification number (EIN) <b>23-4232222</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
10 Contact telephone number <b>2342342342</b>
13 Country and ZIP or foreign postal code <b>23423</b>

**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) <b>1H</b>	1H	1H	1H	1E	1E							
15 Employee Required Contribution (see instructions) <b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>							
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2D</b>	<b>2G</b>	<b>2G</b>							

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(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.

 VOID CORRECTED

OMB No. 1545-2251

**2016**

KARMIESHA ALLEN  
1 Main St  
GREER, RI, 12351

## 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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**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>KARMEISHA ALLEN</b>	2 Social security number (SSN) *****3974	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2B	2B	2B	2B	2B	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

KELLAN LENO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7–13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>KELLAN LENO</b>	2 Social security number (SSN) *****1625	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months												
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> \$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>49.50</b>	\$ <b>49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>												
<b>18</b>												
<b>19</b>												
<b>20</b>												
<b>21</b>												
<b>22</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

MICHAEL POTIER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



STEVEN PAGE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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

**Part I Employee**  
 1 Name of employee  
 STEVEN PAGE  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****5385		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
Plan Start Month (Enter 2-digit number): 11							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
14 Offer of Coverage (enter required code) 1E							
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G							

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

JAMES BABALOLA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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### Part II. Employer Offer and Coverage, Lines 14-16.

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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**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>JAMES BABALOLA</b>	2 Social security number (SSN) *****5214	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**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) <b>1E</b>												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

DAVID WOODFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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	2 Social security number (SSN) *****4173		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
DAVID WOODFORD			9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
3 Street address (including apartment no.)	1 Main St	5 State or province	11 City or town AJO	12 State or province AZ
4 City or town	GREER	6 County and ZIP or foreign postal code 12351	13 Country and ZIP or foreign postal code 23423	

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11										
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1E											
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2C

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(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

VOID       CORRECTED

**2016**

LUISA ROSARIO  
1 Main St  
GREER, RI, 12351

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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 LUISA ROSARIO  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****4575	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
12 State or province AZ			
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

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17			<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

VENUS SIMS  
1 Main St  
GREER, RI, 12351

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- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 VENUS SIMS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
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**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	1E	Plan Start Month (Enter 2-digit number): 11												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
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 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

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17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

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BHANU VOOCHA  
1 Main St  
GREER, RI, 12351

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### Part II. Employer Offer and Coverage, Lines 14-16.

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
**BHANU VOOCHA**  
 3 Street address (including apartment no.)  
**1 Main St**  
 4 City or town  
**GREER**  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	All 12 Months	Plan Start Month (Enter 2-digit number): 11										
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
1E												
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

 VOID

 CORRECTED

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

SUCHARITHA KOMATI  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that continue Part III.

### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
 SUCHARITHA KOMATI  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	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)	2A	2A	2A	2A	2D	2G	2G	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

DAVID DEROHAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**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 I Employee**

1 Name of employee DAVID DEROHAN	2 Social security number (SSN) *****1709	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>															
(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

RMS  
sadfasdf ADFA  
AJO, AZ, 23423

NAZIR NISAR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

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### 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.

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JEFFREY BERGER  
1 Main St  
GREER, RI, 12351

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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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### Part III. 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>JEFFREY BERGER</b>	2 Social security number (SSN) *****3375	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	AJO	11 City or town <b>AJO</b>	10 Contact telephone number 2342342342
12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>		

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2C</b>	<b>2C</b>	<b>2C</b>	<b>2C</b>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

JACKY LIN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 JACKY LIN  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2B

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DAVID EUBANK  
1 Main St  
GREER, RI, 12351

## 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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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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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MATTHEW STEINHOUR  
1 Main St  
GREER, RI, 12351

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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**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

**Part I Employee**  
 Name of employee  
 MATTHEW STEINHOUR  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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"/>

 VOID

 CORRECTED

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

HERNAN FLORES  
1 Main St  
GREER, RI, 12351

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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 continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 <b>HERNAN FLORES</b>	2 Social security number (SSN) *****6533	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>										
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>										
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Required Contribution (see instructions) <b>\$ 2G</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID  
 CORRECTED

OMB No. 1545-2251  
**2016**

JAMES LEE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 JAMES LEE	2 Social security number (SSN) *****2752	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JOSEPH HULGAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>JOSEPH HULGAN</b>	2 Social security number (SSN) *****3196	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1H									
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

RUPAK BARUA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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.

**1A.** Minimum 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 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 RUPAK BARUA	2 Social security number (SSN) *****5728	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
AJO			AZ
			11 City or town AJO

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)		2G	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
RUPAK BARUA	*****5728		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
JAKIA CHOUDHURY	*****7614		<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

Form 1095-C (2016)

VOID       CORRECTED

OMB No. 1545-2251  
2016

### Applicable Large Employer Member (Employer)

1 Name of employer RUPAK BARUA	2 Social security number (SSN) *****5728	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
Sacdfasd ADFA	AJO	11 City or town AJO	12 State or province AZ

### Plan Start Month (Enter 2-digit number): 11

MICHAEL CRAWFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

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### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>MICHAEL CRAWFORD</b>	2 Social security number (SSN) *****8778	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)  1 Main St	4 City or town  GREER RI	5 State or province  12351	9 Street address (including room or suite no.)  Safdfasd ADFA
6 County and ZIP or foreign postal code  AJO	11 City or town  AJO	12 State or province  AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code  23423	13 Country and ZIP or foreign postal code  23423		

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

IMRAN BOKHARI  
1 Main St  
GREER, RI, 12351

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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).

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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

**Part I Employee**  
 1 Name of employee  
 IMRAN BOKHARI  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****7824	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
		11 City or town AZ	12 State or province AZ

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JOHN DAVID  
1 Main St  
GREER, RI, 12351

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HUNG TRAN  
1 Main St  
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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

<b>Part I Employee</b>	
1 Name of employee HUNG TRAN	2 Social security number (SSN) *****7195
3 Street address (including apartment no.) 1 Main St	4 City or town GREER
5 State or province RI	6 County and ZIP or foreign postal code 12351

**Employer-Provided Health Insurance Offer and Coverage**  
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**Applicable Large Employer Member (Employer)**

7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

CHRISTIANE PEREIRA  
1 Main St  
GREER, RI, 12351

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You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>CHRISTIANE PEREIRA</b>	2 Social security number (SSN) *****4870	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

HENOK TEKLE  
1 Main St  
GREER, RI, 12351

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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.

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**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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

**Part I Employee**  
 1 Name of employee  
 HENOK TEKLE  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)

<input type="checkbox"/> VOID	<input type="checkbox"/> CORRECTED
OMB No. 1545-2251	
<b>2016</b>	

<b>Applicable Large Employer Member (Employer)</b>																																																																															
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Cat. No. 60705M

 Form **1095-C** (2016)

SEAN HATHAWAY  
1 Main St  
GREER, RI, 12351

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# 1095-C

Form  
Department of the Treasury  
Internal Revenue Service

**Part I Employee**

## Employer-Provided Health Insurance Offer and Coverage

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1 Name of employee <b>SEAN HATHAWAY</b>	2 Social security number (SSN) *****6739	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
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Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
15 Employee Required Contribution (see instructions) \$ 2G													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Form 1095-C (2016)

JEREMY UZZLE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 JEREMY UZZLE	2 Social security number (SSN) *****0647	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

HOMER NAVOTAS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 HOMER NAVOTAS  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Applicable Large Employer Member (Employer)**

1 Name of employer HOMER NAVOTAS	2 Social security number (SSN) *****0868	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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) 1E													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

JOJO RAPPAL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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

 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 JOJO RAPPALI	2 Social security number (SSN) *****8321	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code AJO	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

MARGARET HUDSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>MARGARET HUDSON</b>	2 Social security number (SSN) *****4395	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2G	2G	2G	2B	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

GAIL ELLS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 GAIL ELLS  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	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)	2A	2A	2A	2A	2A	2D	2G	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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)**

<input type="checkbox"/> VOID	<input type="checkbox"/> CORRECTED
OMB No. 1545-2251	2016

JEROEN DERYCK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 JEROEN DERYCK  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

 VOID  
 CORRECTED

JOHN COPPOLA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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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

**Part I Employee**  
 Name of employee  
 JOHN COPPOLA  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

NAOMI RICHARDSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>NAOMI RICHARDSON</b>	2 Social security number (SSN) *****4794	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> \$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>811.00</b>	\$ <b>49.50</b>	\$ <b>49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
\$ <b>811.00</b>	\$ <b>49.50</b>	\$ <b>49.50</b>										

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

JAMES BLUNDELL  
1 Main St  
GREER, RI, 12351

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

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**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

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### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part 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>JAMES BLUNDELL</b>	2 Social security number (SSN) *****0172	7 Name of employer RMLS	8 Employer identification number (EIN) <b>23-4232222</b>
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number <b>2342342342</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JIGAR PATEL  
1 Main St  
GREER, RI, 12351

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

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**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

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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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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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 JIGAR PATEL	2 Social security number (SSN) *****3858	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
2G												

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JUDY PARETI  
1 Main St  
GREER, RI, 12351

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**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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

**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)**

1 Name of employee JUDY PARETI	2 Social security number (SSN) *****5815	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdfasd ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	Applicable Large Employer Member (Employer)		

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Required Contribution (see instructions) \$ 2C													
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"/>
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

OLUWAKEMI OLAIBIKUNLE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7–13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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.  
**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>OLUWAKEMI OLALIBIKUNLE</b>	2 Social security number (SSN) *****2631	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO AZ</b>
<b>Applicable Large Employer Member (Employer)</b>			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A								

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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"/>

ALEKSANDR BOGOMOLOV  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)**
**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 II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

RICHARD PETERSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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 continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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>RICHARD PETERSON</b>	2 Social security number (SSN) *****0949	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

CAROL MCGUIGAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CAROL MCGUIGAN</b>	2 Social security number (SSN) *****5128	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code) <b>1H</b>													
15 Employee Contribution (see instructions) <b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable) <b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2D</b>	<b>2D</b>	<b>2D</b>	<b>2D</b>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

MONICA BUTOLIA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**Part I Employee**  
 1 Name of employee  
 MONICA BUTOLIA  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****5100	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	11 City or town AZ
		12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**Part III Covered Individuals**

Plan Start Month (Enter 2-digit number): 11			
	Jan	Feb	Mar
	Apr	May	June
14 Offer of Coverage (enter required code) 1E			
15 Employee Required Contribution (see instructions) \$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 49.50			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G			

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
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

MAGAN SCOTT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 MAGAN SCOTT  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****7550	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	11 City or town AZ
		12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**Part III Covered Individuals**

Plan Start Month (Enter 2-digit number): 11													
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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DENNIS SMALLWOOD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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### Part II. Employer Offer and Coverage, Lines 14-16.

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**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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  
**DENNIS SMALLWOOD**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****0821	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)  1 Main St	4 City or town  GREER RI	5 State or province  12351	9 Street address (including room or suite no.)  Safdasdf ADFA
6 County and ZIP or foreign postal code  AJJO	11 City or town  AJJO	12 State or province  AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code  23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (Enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1H													
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

DAVID HOLLIDAY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 DAVID HOLLIDAY  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****1565	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	AJO	11 City or town AZ
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

KIRK REID  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



JUAN FRANCOORTIZ  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)**
**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).

1 Name of employee JUAN FRANCOORTIZ	2 Social security number (SSN) *****1319	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

CASSANDRA SIFFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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 III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>CASSANDRA SIFFORD</b>	2 Social security number (SSN) *****0812	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>15 Employee Required Contribution (see instructions)</b> \$	1H	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2D	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>15 Employee Required Contribution (see instructions)</b> \$	1H	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2D	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

JUSTIN CASSELMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this 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.
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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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# 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>JUSTIN CASSELMAN</b>	2 Social security number (SSN) *****0426	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

### Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A								

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

CODY MHOON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete 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

## 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	2 Social security number (SSN) *****5770		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
CODY MHOON				
3 Street address (including apartment no.)			9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
1 Main St				
4 City or town	5 State or province	6 County and ZIP or foreign postal code	11 City or town AJO	12 State or province AZ
GREER	RI	12351		

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	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"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

KENNETH KING  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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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 KENNETH KING	2 Social security number (SSN) *****2716	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter required code) 1E		
15 Employee Contribution (see instructions) \$ 811.00	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	17	18
19	20	21	22

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

TRINE MICKELSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 TRINE MICHELSON	2 Social security number (SSN) *****38700	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1H							
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A

**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)	1E	1E	1E	1E	1H							
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17											
18											
19											
20											
21											
22											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

BARBARA IACHELLO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 <b>BARBARA IACHELLO</b>	2 Social security number (SSN) *****0869	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
Safdasdf ADFA	AJO	11 City or town <b>AZ</b>	12 State or province <b>AZ</b>

**Applicable Large Employer Member (Employer)**

9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342											
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>											
13 Country and ZIP or foreign postal code <b>23423</b>												
<b>Plan Start Month</b> (Enter 2-digit number): <b>11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1E	1E								
15 Employee Contribution (see instructions)	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2G								

**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)	1H	1H	1E	1E								
15 Employee Contribution (see instructions)	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2G								

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

JASON ROBERTSON  
1 Main St  
GREER, RI, 12351

## 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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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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### Part II. Employer Offer and Coverage, Lines 14-16.

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**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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>JASON ROBERTSON</b>	2 Social security number (SSN) *****2182	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

APRIL FINLEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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TIMOTHY MASON  
1 Main St  
GREER, RI, 12351

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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**

► Do not attach to your tax return. Keep for your records.

**Part I Employee**

1 Name of employee <b>TIMOTHY MASON</b>	2 Social security number (SSN) *****0037	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): <b>11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<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)

WELDON YOUNG  
1 Main St  
GREER, RI, 12351

## 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).

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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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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>WELDON YOUNG</b>	2 Social security number (SSN) *****2799	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1H	1H
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2D	2G	2G	2B	2B	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Cat. No. 60705M

Form 1095-C (2016)

ISIDRO PARRA  
1 Main St  
GREER, RI, 12351

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 ISIDRO PARRA  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

 VOID

 CORRECTED

GREGORY RENKEN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>GREGORY RENKEN</b>	2 Social security number (SSN) *****8604	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED**2016**

GERALD WILLIAMS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 <b>GERALD WILLIAMS</b>	2 Social security number (SSN) *****1732	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

ZULMA TSAVDAR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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### Part III. Covered Individuals, Lines 17-22

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**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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 ZULMA TSAVNDAR	2 Social security number (SSN) *****8801	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)	1H	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JACK TELFORD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>JACK TELFORD</b>	2 Social security number (SSN) *****9314	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

Form  
Department of the Treasury  
Internal Revenue Service► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c) VOID CORRECTED**2016**

KATRINA TODDKRASEN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
**KATRINA TODDKRASEN**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**  
 County and ZIP or foreign postal code  
**AJO AZ**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

AMOL MORE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 AMOL MORE  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****5076		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
9 Street address (including room or suite no.) Safdasdf ADFA							
10 Contact telephone number 2342342342		11 City or town AJO		12 State or province AZ		13 Country and ZIP or foreign postal code 23423	
<b>Plan Start Month</b> (Enter 2-digit number): 11							
All 12 Months		Jan	Feb	Mar	Apr	May	June
1E		1E	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)		\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G
		2G	2G	2G	2G	2B	2A
						2A	2A
							2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

LAURA GOLDSTONE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Part I Employee**

1 Name of employee <b>LAURA GOLDSTONE</b>	2 Social security number (SSN) *****2900	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>										
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>										
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Required Contribution (see instructions) <b>2G</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

JENNIFER LECOINTE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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.

► 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>JENNIFER LECOINTE</b>	2 Social security number (SSN) *****5530	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
<b>2C</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

**Part II** VOID       CORRECTED**2016**

OMB No. 1545-2251

HECTOR ROMERO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>HECTOR ROMERO</b>	2 Social security number (SSN) *****8747	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	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)	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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)

JASON VALENTINEWILEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**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).

1 Name of employee JASON VALENTINEWILEY	2 Social security number (SSN) *****1101	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

DARRYL BROOKS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
**DARRYL BROOKS**  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****1223		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423		
<b>Part II Employee Offer of Coverage</b>							
14 Offer of coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

OPHER BANARIE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
**OPHER BANARIE**  
 ▶ Do not 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): 11												
	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)	2A	2A	2A	2A	2A	2A	2D	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****9427	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER RI	12351	AJO AZ

**Part IV**

LAIQUE AHMAD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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 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  
 LAIQUE AHMAD  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

THOMAS FILLEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>THOMAS FILLEY</b>	2 Social security number (SSN) *****8589	7 Name of employer RMLS
--	---	----------------------------

3 Street address (including apartment no.)

1 Main St

4 City or town  
**GREER**

RI

5 State or province  
123516 County and ZIP or foreign postal code  
AJJO

AZ

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A								

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

VOID       CORRECTED

**2016**

Cat. No. 60705M

Form **1095-C** (2016)

ALAN BURNETT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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  
 ALAN BURNETT  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E	1E	1E	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G
17													
18													
19													
20													
21													
22													

**Part III Covered Individuals**

	(a) Name of covered individual(s)	(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					
18					
19					
20					
21					
22					

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

PETER KERNER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this 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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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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).

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 PETER KERNER  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Employee**

1 Name of employee	2 Social security number (SSN) *****0620		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) 1 Main St	9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342										
4 City or town GREER RI	5 State or province 12351	6 County and ZIP or foreign postal code AJO	11 City or town AZ	12 State or province AZ									
Plan Start Month (Enter 2-digit number): 11													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

MICHAEL LONCARIC  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

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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>MICHAEL LONCARIC</b>	2 Social security number (SSN) *****0476	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	AJO	11 City or town <b>AZ</b>	10 Contact telephone number 2342342342
		12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

GERALD NAPLES  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
**GERALD NAPLES**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****4699		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

BASKAR WALLAJABAD  
1 Main St  
GREER, RI, 12351

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 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

**Part I Employee**  
 Name of employee  
 BASKAR WALLAJABAD  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2G	2G								

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

JUANCARLOS RENTERIA  
1 Main St  
GREER, RI, 12351

## 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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### 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).

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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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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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 JUANCARLOS RENTERIA	2 Social security number (SSN) *****8426	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code 12351	10 Contact telephone number 2342342342
		11 City or town AJO	12 State or province AZ
		13 Country and ZIP or foreign postal code 23423	

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	

JAMES LATZKE  
1 Main St  
GREER, RI, 12351

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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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**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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**  
 Name of employee  
 JAMES LATZKE  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID  
 CORRECTED

 OMB No. 1545-2251  
**2016**

WILLIAM FITZPATRICK  
1 Main St  
GREER, RI, 12351

## 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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**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).
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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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ANISA WALTERS  
1 Main St  
GREER, RI, 12351

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

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**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>ANISA WALTERS</b>	2 Social security number (SSN) *****0735	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	All 12 Months	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

JULIA CAGNEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 VOID       CORRECTED  
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**Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)**
**Employer-Provided Health Insurance Offer and Coverage**
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**Part II Employee Offer of Coverage**

		Applicable Large Employer Member (Employer)											
1 Name of employee		2 Social security number (SSN) ***** 6771		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222							
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO		9 Street address (including room or suite no.) Safdfasd ADFA		10 Contact telephone number 2342342342			
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E													
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

SUDHIR JARAJAPU  
1 Main St  
GREER, RI, 12351

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 SUDHIR JARAJAPU  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****3378		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$ Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

GARY OPERHALL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.



DOUGLAS DREXLER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>DOUGLAS DREXLER</b>	2 Social security number (SSN) *****0627	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	AJO	11 City or town <b>AJO</b>	10 Contact telephone number 2342342342
12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>		

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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
<b>17 DOUGLAS DREXLER</b>	*****0627		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>18 DAWN DREXLER</b>	*****3264		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>19 BRANDON DREXLER</b>	*****5220		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>20 CALEB DREXLER</b>	*****8148		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>21 ETHAN DREXLER</b>	*****2700		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<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)

LARRY ORMAND  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

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**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### 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>LARRY ORMAND</b>	2 Social security number (SSN) *****4439	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	<b>1E</b>												
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	<b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED

OMB No. 1545-2251

**2016**

JESSE NEWSHAM  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.



DIANA NAVARRETO  
1 Main St  
GREER, RI, 12351

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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 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  
 DIANA NAVARRETO  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****7015	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	12351	11 City or town AJJO
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
\$	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

ALYSSA GILLETT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
 ALYSSA GILLETT  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****2905	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO
4 City or town	6 County and ZIP or foreign postal code 12351	12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

PETER McFARLAND  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
**PETER MC FARLAND**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**  
 County and ZIP or foreign postal code  
**AJO**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****4470	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	12351	11 City or town AJO
12 State or province AZ			
13 Country and ZIP or foreign postal code 23423			

**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)	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

ANDREA DAVIDSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>ANDREA DAVIDSON</b>	2 Social security number (SSN) *****2769	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	1H
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

SONALI KHARE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

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### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.



CHARLES MINCHEW  
1 Main St  
GREER, RI, 12351

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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**  
 1 Name of employee  
 CHARLES MINCHEW  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Applicable Large Employer Member (Employer)**

1 Name of employer CHARLES MINCHEW	2 Social security number (SSN) *****84999	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

TRAVIS LAGINESS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part I. Employee.

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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>TRAVIS LAGINNESS</b>	2 Social security number (SSN) *****5892	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Form 1095-C (2016)

MICHAEL HENNIG  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 MICHAEL HENNIG  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID

 CORRECTED

 OMB No. 1545-2251  
**2016**

MAHENDER KUNTA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**Form  
Department of the Treasury  
Internal Revenue Service**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>MAHENDER KUNTA</b>	2 Social security number (SSN) *****1257	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>											
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>											
Plan Start Month (Enter 2-digit number): <b>11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

**Part 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)	1E	1H	1H									
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A									

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form  
Department of the Treasury  
Internal Revenue Service VOID       CORRECTED► Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c).**2016**

OMB No. 1545-2251

CHARLES SAWYER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
**CHARLES SAWYER**  
 ▶ Do not 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) *****1026		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
Plan Start Month (Enter 2-digit number): 11							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
14 Offer of Coverage (enter required code) 1E							
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

KEITH SMITH  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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 KEITH SMITH	2 Social security number (SSN) *****8578	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

CATHERINE LANE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CATHERINE LANE</b>	2 Social security number (SSN) *****6046	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

OLLIE SMITH  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 OLLIE SMITH  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****1745		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI		5 State or province 12351	6 County and ZIP or foreign postal code AJJO									
<b>Plan Start Month</b> (Enter 2-digit number): 11													
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)	1H												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	2A	2A	2A	2D	2B	2B	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

LASHONDA HUGGINS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage 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  
**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 LASHONDA HUGGINS	2 Social security number (SSN) *****9052	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

SCOTT SCHUMAN  
1 Main St  
GREER, RI, 12351

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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 <b>SCOTT SCHUMAN</b>	2 Social security number (SSN) *****6760	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2C</b>	<b>2C</b>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

FRANCISCO BEJAR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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	2 Social security number (SSN) *****7460		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
FRANCISCO BEJAR			9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
3 Street address (including apartment no.)	1 Main St	5 State or province	11 City or town AJO	12 State or province AZ
4 City or town	GREER	6 County and ZIP or foreign postal code 12351	13 Country and ZIP or foreign postal code 23423	

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	1E	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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)

ERIC WENOKOR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 ERIC WENOKOR	2 Social security number (SSN) *****7409	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

PAUL BROWN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>PAUL BROWN</b>	2 Social security number (SSN) *****7868	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months 1E												
14 Offer of Coverage (enter required code)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

### Part II Employee Offer of Coverage

All 12 Months 1E	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

RMS  
sadfasdf ADFA  
AJO, AZ, 23423

LINUS LINN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)**

<input type="checkbox"/> VOID	<input type="checkbox"/> CORRECTED	OMB No. 1545-2251																																																				
<b>2016</b>		8 Employer identification number (EIN) 23-4232222																																																				
<b>Applicable Large Employer Member (Employer)</b>		9 Street address (including room or suite no.) Safdfasd ADFA																																																				
		10 Contact telephone number 2342342342																																																				
		11 City or town AJJO																																																				
		12 State or province AZ																																																				
		13 Country and ZIP or foreign postal code 23423																																																				
<b>Part II Employee Offer of Coverage</b> <table border="1"> <thead> <tr> <th>All 12 Months</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>June</th> <th>July</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> </tr> </thead> <tbody> <tr> <td>1E</td> <td>1E</td> <td>1E</td> <td>1H</td> </tr> <tr> <td>\$ 811.00</td> <td>\$ 811.00</td> <td>\$ 811.00</td> <td>\$</td> </tr> <tr> <td>2G</td> <td>2G</td> <td>2G</td> <td>2B</td> <td>2B</td> <td>2A</td> <td>2A</td> <td>2A</td> <td>2A</td> <td>2A</td> <td>2A</td> <td>2A</td> <td>2A</td> </tr> </tbody> </table>			All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	1E	1E	1E	1H	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	2G	2G	2G	2B	2B	2A																
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2G	2G	2G	2B	2B	2A																																																	
<b>Part III Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/> (a) Name of covered individual(s)      (b) SSN or other TIN      (c) DOB (If SSN or other TIN is not available)      (d) Covered all 12 months      (e) Months of Coverage																																																						
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22					<input type="checkbox"/>																																																	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

NATHAN MATHIS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum 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.

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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

**Part I Employee**  
 Name of employee  
 NATHAN MATHIS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****6217	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
12 State or province AZ			
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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"/>
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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.

SHERRI CRUMBACHER  
1 Main St  
GREER, RI, 12351

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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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### 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 <b>SHERRI CRUMBACHER</b>	2 Social security number (SSN) *****6084	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdfasd ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

SETH BEAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 SETH BEAN  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												
<b>Plan Start Month (Enter 2-digit number): 11</b>													

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

 VOID

 CORRECTED

RICHARD FERRI  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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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

**Part I Employee**  
 1 Name of employee  
 RICHARD FERRI  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

JOSEPHINE ONDRUSEK  
1 Main St  
GREER, RI, 12351

## 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.

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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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### 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  
 ▶ Do not 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)**
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****6975		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
9 Street address (including room or suite no.) Safdfasd ADFA							
10 Contact telephone number 2342342342		11 City or town AJO		12 State or province AZ		13 Country and ZIP or foreign postal code 23423	
<b>Plan Start Month</b> (Enter 2-digit number): 11							
All 12 Months		Jan	Feb	Mar	Apr	May	June
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1E	July
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	Aug
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	Sept
							Oct
							Nov
							Dec
							1H
							1H
							1H
							2A
							2A
							2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RANDARUS MARTIN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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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.

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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 RANDARUS MARTIN	2 Social security number (SSN) *****9712	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED

OMB No. 1545-2251

**2016**Form **1095-C** (2016)

Cat. No. 60705M

MICHAEL FRIEDMAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>MICHAEL FRIEDMAN</b>	2 Social security number (SSN) *****5205	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	AJO	11 City or town <b>AZ</b>	10 Contact telephone number 2342342342
		12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

RONALD ROBY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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.



SAHIL ARORA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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Part 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  
**SAHIL ARORA**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****0770		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
Offer of Coverage (Enter required code)							
Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

CHARLES WALLACEJr  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CHARLES WALLACE Jr</b>	2 Social security number (SSN) *****9744	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months <b>1E</b>												
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months <b>1E</b>	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>												
<b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

DAVID REIS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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

**Part I Employee**  
 1 Name of employee  
 DAVID REIS  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****6611	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	6 County and ZIP or foreign postal code AJO									
<b>Plan Start Month</b> (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

KATRINA WILLIAMS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 KATRINA WILLIAMS	2 Social security number (SSN) *****1457	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

EDMOND JONESJr  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 EDMOND JONES Jr  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1H												
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

SUNDARA NARASIMHAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)**
**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)
**Applicable Large Employer Member (Employer)**

1 Name of employee SUNDARA NARASIMHAN	2 Social security number (SSN) *****8436	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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) 1E													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

WILLIAM SENIZAIZ  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**

## Employer-Provided Health Insurance Offer and Coverage

► Do not 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

WILLIAM SENIZAIZ

### 3 Street address (including apartment no.)

1 Main St

### 4 City or town

GREER RI

### 5 State or province

12351

### 6 County and ZIP or foreign postal code

AJO

### Part II Employee Offer of Coverage

### Applicable Large Employer Member (Employer)

1 Name of employer	2 Social security number (SSN) *****1052	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423

### Plan Start Month (Enter 2-digit number): 11

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1E	1H									
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2G	2G	2B	2B	2A						

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

NATHANIEL RICHARDSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

1 Name of employee <b>NATHANIEL RICHARDSON</b>	2 Social security number (SSN) *****7835	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

JIMMY CHEUNG  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 Name of employee  
 JIMMY CHEUNG  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****3646	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)		9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
1 Main St		11 City or town AJO	12 State or province AZ

**Plan Start Month (Enter 2-digit number): 11**

NICHOLAS SIKIRICA  
1 Main St  
GREER, RI, 12351

## 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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**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	Applicable Large Employer Member (Employer)											
	2 Social security number (SSN) *****2144	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423	14	15	16	17
1 Main St	5 State or province RI	6 County and ZIP or foreign postal code 12351							All 12 Months	Jan	Feb	Mar
GREER									1H	1H	1H	1H
14 Offer of Coverage (enter required code)	\$	\$	\$	\$	\$	\$	\$	\$	May	June	July	Aug
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	Sept	Oct	Nov	Dec
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	1H	1H	1H	1H
									AUG	SEP	OCT	NOV
									1E	1E	1E	1E

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is 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"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

RONALD HUDSPETH  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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**

## Employer-Provided Health Insurance Offer and Coverage

► Do not 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 <b>RONALD HUDSPETH</b>	2 Social security number (SSN) *****4253	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

## Applicable Large Employer Member (Employer)

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G

## Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G

## Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17											
18											
19											
20											
21											
22											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

PRASHANTH KARANAM  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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  
 ▶ Do not 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)**
**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 II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****1695		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

KEVIN COLLINS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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>KEVIN COLLINS</b>	2 Social security number (SSN) *****7583	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	AJO	11 City or town <b>AJO</b>	10 Contact telephone number 2342342342
12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>		

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>													
<b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

JHAN CACERES  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 Name of employee  
 JHAN CACERES  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****5788	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1E	1E	1E	1E	1E	1E	1H						
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

CATHERINE MACHO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CATHERINE MACHO</b>	2 Social security number (SSN) *****8732	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	6 County and ZIP or foreign postal code AJJO
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1H	1H
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2G	2G	2G	2B	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

CHRISTOPHER WOODWARD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CHRISTOPHER WOODWARD</b>	2 Social security number (SSN) *****9276	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months <b>1E</b>												
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

### Part II Employee Offer of Coverage

All 12 Months <b>1E</b>	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>15 Employee Required Contribution (see instructions)</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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**

WILLIAM DEANGELO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>WILLIAM DEANGELO</b>	2 Social security number (SSN) *****6406	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>										
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>										
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Contribution (see instructions) <b>\$ 2G</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

MATTHEW ROBINSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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 <b>MATTHEW ROBINSON</b>	2 Social security number (SSN) *****8604	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

1 Name of employee <b>MATTHEW ROBINSON</b>	2 Social security number (SSN) *****8604	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

KURT SOMMERHAUSER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.



PATRICK SHAW  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 <b>PATRICK SHAW</b>	2 Social security number (SSN) *****5834	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months 1E												
14 Offer of Coverage (enter required code) Required Contribution (see instructions) <b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
15 Employee Contributions (see instructions) <b>2G</b>												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part II Employee Offer of Coverage

All 12 Months 1E	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) Required Contribution (see instructions) <b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
15 Employee Contributions (see instructions) <b>2G</b>												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID       CORRECTED      **2016**

OMB No. 1545-2251  
Form 1095-C (2016)

AVINASH CHIDDARWAR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.  
**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>AVINASH CHIDDARWAR</b>	2 Social security number (SSN) *****5657	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

MASON SHAW  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 MASON SHAW  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****7351	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E	1E	1E	1E	1E	1E	1H						
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

ADRIAN CROWELL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 ADRIAN CROWELL  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****8758	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
		11 City or town AZ	12 State or province AZ

**Part III Covered Individuals**

Plan Start Month (Enter 2-digit number): 11			
All 12 Months	Jan	Feb	Mar
14 Offer of Coverage (Enter required code)	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$
	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A
	2A	2A	2A
17	2G	2G	2G
	2G	2G	2G
18	2G	2G	2G
	2G	2G	2G
19	2G	2G	2G
	2G	2G	2G
20	2G	2G	2G
	2G	2G	2G
21	2G	2G	2G
	2G	2G	2G
22	2G	2G	2G

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

BRIAN MOSES  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>BRIAN MOSES</b>	2 Social security number (SSN) *****8770	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

### 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) <b>1E</b>												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251  
2016

JOHN MILANO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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)**

1 Name of employee JOHN MILANO	2 Social security number (SSN) *****2638	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**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)	1H	1H	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Contribution (see instructions)	\$	\$	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2G	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

DAVID ALBARRAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 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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JYOTHI DHANAPAL  
1 Main St  
GREER, RI, 12351

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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 JYOTHI DHANAPAL	2 Social security number (SSN) *****6527	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

2016

Form 1095-C (2016)

VENKATA PASUPULETI  
1 Main St  
GREER, RI, 12351

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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 VENKATA PASUPULETI	2 Social security number (SSN) *****4354	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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"/>
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

ZINA KLANG  
1 Main St  
GREER, RI, 12351

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GLENN HAYES  
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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part 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  
**GLENN HAYES**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****6891		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16	Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G					

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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)

DONNA POFF  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>DONNA POFF</b>	2 Social security number (SSN) *****8263	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E	1E	1E	1H								
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A						

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

BRIAN SCHLENKER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 <b>BRIAN SCHLENKER</b>	2 Social security number (SSN) *****2827	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

<b>Applicable Large Employer Member (Employer)</b>	
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342

<b>Plan Start Month (Enter 2-digit number): 11</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>										
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b>	<b>2G</b>											

**Part II Employee Offer of Coverage**

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)
<b>1E</b>	<b>\$ \$ 811.00</b>	<b>2G</b>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>22</b>			<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)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

LEONARDO VO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

# 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>LEONARDO VO</b>	2 Social security number (SSN) *****2050	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
2G												

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

RUBENS INABA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 RUBENS INABA  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E	1E	1E	1E	1E	1H							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****9027	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER RI	12351	AJO

**Plan Start Month (Enter 2-digit number):** 11

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
All 12 Months	1E	1E	1E	1E	1E	1H						
14 Offer of Coverage (enter required code)												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

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17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

JUSTIN MILETTE  
1 Main St  
GREER, RI, 12351

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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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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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 <b>JUSTIN MILLETTE</b>	2 Social security number (SSN) *****6661	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
AJJO	AJO	AZ	AZ

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	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"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED**2016**

OMB No. 1545-2251

Form **1095-C** (2016)

Cat. No. 60705M

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

TRAVIS KMIECIAK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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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**  
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**Part I Employee**

1 Name of employee TRAVIS KMIECIAK	2 Social security number (SSN) *****9406	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**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)	1H	1E	1E									
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2G	2G									

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

AUTEAH FARAG  
1 Main St  
GREER, RI, 12351

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 AUTEAH FARAG  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****7826	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI	5 State or province 12351	9 Street address (including room or suite no.) Safdasdf ADFA
		6 County and ZIP or foreign postal code AJO	11 City or town AZ
		12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**Part III Covered Individuals**

Plan Start Month (Enter 2-digit number): 11													
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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(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)

WILLIAM HALL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 WILLIAM HALL  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C	2C	2C	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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"/>

PATILLA MITCHELL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>PATILLA MITCHELL</b>	2 Social security number (SSN) *****0017	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

DARNELL BROWN  
1 Main St  
GREER, RI, 12351

## 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.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>DARNELL BROWN</b>	2 Social security number (SSN) *****6312	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>

**Applicable Large Employer Member (Employer)**

8 Employer identification number (EIN) <b>23-4232222</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
10 Contact telephone number <b>2342342342</b>
13 Country and ZIP or foreign postal code <b>23423</b>

**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) <b>1E</b>												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

ANDREW MACKEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.



JOHNPALU BENEDICTO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**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 I Employee**

1 Name of employee JOHNPAL BENEDICTO	2 Social security number (SSN) *****7304	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

NATOSHIA LEWIS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.  
**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>NATOSHIA LEWIS</b>	2 Social security number (SSN) *****7606	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

## Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

## Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

KEVIN JOHNSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**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>KEVIN JOHNSON</b>	2 Social security number (SSN) *****8482	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (Enter required code)	1H	1H	1H	1E	1E	1E	1E	1E	1E	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)	2A	2A	2A	2G	2G	2G	2G	2G	2G	2B	2B	2A	

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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)

LAURIE EISENMANN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.

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**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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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VICTOR MERCED  
1 Main St  
GREER, RI, 12351

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 VICTOR MERCED  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
 5 State or province  
 RI  
 6 County and ZIP or foreign postal code  
 12351

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****94944	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO
4 City or town	12 State or province AZ	13 Country and ZIP or foreign postal code 23423	14 Offer of coverage (enter required code)
GREER RI			15 Employee Required Contribution (see instructions)
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	17	18	19
2G	2G	2B	2A
2G	2G	2A	2A

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2G	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

CHARNKIAT SUK PANICHNANT  
1 Main St  
GREER, RI, 12351

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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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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**
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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 CHARNKIAT SUK PANICHNANT	2 Social security number (SSN) *****7169	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

<b>Part II Employee Offer of Coverage</b>		<b>Plan Start Month</b> (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1H									
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

RAJAGOPAL PILLAI  
1 Main St  
GREER, RI, 12351

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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>RAJAGOPAL PILLAI</b>	2 Social security number (SSN) *****2240	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID  
 CORRECTED

OMB No. 1545-2251  
**2016**

GAR MAGNER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 GAR MAGNER  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****11151		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdfasd ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

WENSEAN PAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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 continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 <b>WENSEAN PAN</b>	2 Social security number (SSN) *****9059	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
Safdasdf ADFA	AJO	11 City or town <b>AZ</b>	12 State or province <b>AZ</b>

**Applicable Large Employer Member (Employer)**

9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>	

**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)	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1H	1H	1H
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2D	2G	2G	2G	2G	2G	2B	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

MARKUS RAWSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>MARKUS RAWSON</b>	2 Social security number (SSN) *****3765	7 Name of employer RMLS
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	8 Employer identification number (EIN) 23-4232222
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	13 Country and ZIP or foreign postal code <b>AZ</b>
12 State or province <b>23423</b>	Applicable Large Employer Member (Employer)	

**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) <b>1E</b>												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

RYAN WILSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 RYAN WILSON  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****2311		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER RI		11 City or town AJO AZ		12 State or province AZ	
<b>Part II Employee Offer of Coverage</b>							
14 Offer of coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
15 Employee Required Contribution (see instructions)	\$ 811.00	1E	1E	1E	1E	1E	1E
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

DARRYL VAUGHN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>DARRYL VAUGHN</b>	2 Social security number (SSN) *****4483	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (Enter required code) <b>1H</b>													
15 Employee Contribution (see instructions) <b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable) <b>2A</b>	<b>2A</b>	<b>2A</b>	<b>2D</b>	<b>2B</b>	<b>2B</b>	<b>2A</b>							

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

JONATHAN GUTIERREZ  
1 Main St  
GREER, RI, 12351

## 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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**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 <b>JONATHAN GUTIERREZ</b>	2 Social security number (SSN) *****0962	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>										
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>										
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
15 Employee Required Contribution (see instructions) <b>\$ 2G</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>													

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

CHRISTOPHER BRETT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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### Part II. Employer Offer and Coverage, Lines 14-16.

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- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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**  
 1 Name of employee  
**CHRISTOPHER BRETT**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID

 CORRECTED

 OMB No. 1545-2251  
**2016**
**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****7153	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	4 City or town	5 State or province	6 County and ZIP or foreign postal code
1 Main St	GREER RI	12351	AJO AZ

**Part IV**

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

ELENA KHOPERSKAYA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7–13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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.  
**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 ELENA KHOPERSKAYA	2 Social security number (SSN) *****4911	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2D	2G	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"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Form **1095-C** (2016)

JAMES WISWELL  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 JAMES WISWELL  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****3081	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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)	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A
<b>Plan Start Month (Enter 2-digit number): 11</b>													

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(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

ANAND RAMASAMY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



JOHN SELENSKY  
1 Main St  
GREER, RI, 12351

## 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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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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 <b>JOHN SELENSKY</b>	2 Social security number (SSN) *****5878	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1H									
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

RONALD GYORFI  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 RONALD GYORFI  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

►

Do not attach to your tax return. Keep for your records.

**Applicable Large Employer Member (Employer)**

1 Name of employer RONALD GYORFI	2 Social security number (SSN) *****4090	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22				<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

CHRISTOPHER WHYTE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>CHRISTOPHER WHYTE</b>	2 Social security number (SSN) *****3606	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

## Part II Employee Offer of Coverage

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2G	2A									

## Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

ALEXIS WOLD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 ALEXIS WOLD  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
**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)	1E	1E	1E	1H									
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>
18			<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"/>

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****8731	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)		9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
1 Main St		11 City or town AJO	12 State or province AZ

**Plan Start Month (Enter 2-digit number):** 11

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1H								
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A						

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

BEVERLY SEECHARRAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is 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 III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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  
**BEVERLY SEECHARRAN**  
 Street address (including apartment no.)  
**1 Main St**  
 City or town  
**GREER RI**  
 State or province  
**12351**
**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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	2 Social security number (SSN) *****7957	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code	10 Contact telephone number 2342342342
GREER	RI	12351	11 City or town AJJO
			12 State or province AZ
			13 Country and ZIP or foreign postal code 23423

**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)	1H												
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2D	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

PRADEEP KUMAR  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>PRADEEP KUMAR</b>	2 Social security number (SSN) *****3980	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID

CORRECTED

OMB No. 1545-2251

**2016**

PATRICIA ROBERTSON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



STEFAN BOWERS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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 reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>STEFAN BOWERS</b>	2 Social security number (SSN) *****1900	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	

**Applicable Large Employer Member (Employer)**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>15 Employee Required Contribution (see instructions)</b> \$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

**Part II Employee Offer of Coverage**

Plan Start Month (Enter 2-digit number): 11												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>15 Employee Required Contribution (see instructions)</b> \$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

MARK BIERMAN  
1 Main St  
GREER, RI, 12351

## 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

**Part I Employee**  
 1 Name of employee  
 MARK BIERMAN  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

	Applicable Large Employer Member (Employer)											
1 Name of employee	2 Social security number (SSN) *****6687											
3 Street address (including apartment no.)	7 Name of employer RMLS											
1 Main St	5 State or province	6 County and ZIP or foreign postal code	9 Street address (including room or suite no.)	10 Contact telephone number								
GREER	RI	12351	Sacfasdf ADFA	2342342342	11 City or town	12 State or province	13 Country and ZIP or foreign postal code	AJO	AZ	23423		

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

ALYSSA BRIGGS  
1 Main St  
GREER, RI, 12351

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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>ALYSSA BRIGGS</b>	2 Social security number (SSN) *****6377	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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)

MARK BEEZHOLD  
1 Main St  
GREER, RI, 12351

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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).

1 Name of employee <b>MARK BEEZHOLD</b>	2 Social security number (SSN) *****4071	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

## 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) <b>1E</b>												
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(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
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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"/>
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"/>
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"/>
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"/>
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"/>
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Cat. No. 60705M

Form 1095-C (2016)

JAYME BROWER  
1 Main St  
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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
**Employee**

► Do not 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 JAIME BROWER	2 Social security number (SSN) *****8803	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	1E	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G													\$ 49.50

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

JAMIE WHITE  
1 Main St  
GREER, RI, 12351

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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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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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RICHA MADAAN  
1 Main St  
GREER, RI, 12351

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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- 1A.** Minimum 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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- 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).
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PREMILAN DURAIRAJ  
1 Main St  
GREER, RI, 12351

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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

**Part I Employee**  
 Name of employee  
 PREMILAN DURAIRAJ  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**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): 11												
	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)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

GREGORY HOLLINS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 GREGORY HOLLINS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****9013	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	11 City or town AZ	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H
\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2B	2B	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RAHUL PANDEY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
**RAHUL PANDEY**  
 ▶ Do not 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) *****2427		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1H							
Offer of Coverage (Enter required code)	\$	\$	\$	\$	\$	\$	\$
Employee Required Contribution (see instructions)	2A	2D	2A	2A	2A	2A	2A
Safe Harbor and Other Relief (Enter code, if applicable)							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

JESSICA HARKER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7–13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>JESSICA HARKER</b>	2 Social security number (SSN) *****0351	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

### Part II Employee Offer of Coverage

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

### Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

VOID  
 CORRECTED

OMB No. 1545-2251  
**2016**

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)

ALEX MASSOTH  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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  
 ALEX MASSOTH  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) *****7251	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	11 City or town AZ

**Plan Start Month (Enter 2-digit number):** 11

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)												
15 Employee Required Contribution (see instructions)	\$ \$	811.00	811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G											

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

DAVID KIRKLAND  
1 Main St  
GREER, RI, 12351

## 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).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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  
 DAVID KIRKLAND  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	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)	2A	2A	2A	2A	2A	2A	2A	2A	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

 VOID       CORRECTED

 OMB No. 1545-2251  
**2016**

JESSE HEBERT  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Employee**  
 VOID       CORRECTED  
**1095-C**      **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 <b>JESSE HEBERT</b>	2 Social security number (SSN) *****3665	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2D	2D	2G	2G	2G	2G	2G

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<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
18			<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
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)

KENT ARENDS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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**  
 Name of employee  
 KENT ARENDS  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****4968	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
12 State or province AZ			
13 Country and ZIP or foreign postal code 23423			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

RAMESH VASIREDDY  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>RAMESH VASIREDDY</b>	2 Social security number (SSN) *****2983	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO</b>									
<b>Part II Employee Offer of Coverage</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (enter required code)</b> <b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b> <b>\$ \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 811.00 \$ 49.50 \$ 49.50</b>												
<b>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)</b> <b>2G</b>												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>22</b>			<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**2016**

OMB No. 1545-2251

VICENTE VALENCIA  
1 Main St  
GREER, RI, 12351

## 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 VICENTE VALENCIA	2 Social security number (SSN) *****7295	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
		6 County and ZIP or foreign postal code 12351	10 Contact telephone number 2342342342
		11 City or town AJJO	12 State or province AZ
		13 Country and ZIP or foreign postal code 23423	

### 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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	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 VICENTE VALENCIA	*****7295		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18 SANDRA DIEGUEZ	*****0547		<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251  
**2016**

OLEKSANDR KOVACH  
1 Main St  
GREER, RI, 12351

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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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**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>OLEKSANDR KOVACH</b>	2 Social security number (SSN) *****7654	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

JUSTIN BENEDICK  
1 Main St  
GREER, RI, 12351

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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**

► Do not attach to your tax return. Keep for your records.

**Part I Employee**

1 Name of employee <b>JUSTIN BENEDICK</b>	2 Social security number (SSN) *****6038	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50

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18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Cat. No. 60705M

Form **1095-C** (2016)

MERRIE LAWTHER  
1 Main St  
GREER, RI, 12351

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**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



ADAM PLANETA  
1 Main St  
GREER, RI, 12351

## 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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**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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**  
 ▶ Do not 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 ADAM PLANETA	2 Social security number (SSN) *****0654	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

ASHANTA WARRICK  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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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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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 ASHANTA WARRICK  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	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)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G	2G

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

MARK OLIVER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete 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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- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored 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

**Part I Employee**  
 1 Name of employee  
**MARK OLIVER**  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

<b>Applicable Large Employer Member (Employer)</b>	
1 Name of employer <b>MARK OLIVER</b>	2 Social security number (SSN) *****2127
3 Street address (including apartment no.) <b>1 Main St</b>	7 Name of employer RMLS
4 City or town <b>GREER</b>	5 State or province <b>RI</b>
6 County and ZIP or foreign postal code <b>12351</b>	9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>
AJO	11 City or town <b>AJO</b>
AZ	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>	

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**
**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

JOHN POSADA  
1 Main St  
GREER, RI, 12351

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- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

<b>Employer-Provided Health Insurance Offer and Coverage</b>	
► Do not attach to your tax return. Keep for your records.	
► Information about Form 1095-C and its separate instructions is at <a href="http://www.irs.gov/form1095c">www.irs.gov/form1095c</a> .	

**Part I Employee**

1 Name of employee JOHN POSADA	2 Social security number (SSN) *****0910	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**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) 1E												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G												

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

DANIEL COLON  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>DANIEL COLON</b>	2 Social security number (SSN) *****1804	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222									
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>									
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>									
13 Country and ZIP or foreign postal code <b>23423</b>	Plan Start Month (Enter 2-digit number): <b>11</b>											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>												
15 Employee Required Contribution (see instructions) <b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2G</b>												

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	<b>\$ 811.00</b>	<b>\$ 49.50</b>										

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

SYLVESTER COLLINS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 <b>SYLVESTER COLLINS</b>	2 Social security number (SSN) *****8579	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

BYRON FUNG  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 BYRON FUNG  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

1 Name of employee		2 Social security number (SSN) *****8708		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423	
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province AZ	14	15
<b>Part II Employee Offer of Coverage</b>							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
1E							
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> June
18			<input type="checkbox"/>	<input type="checkbox"/> July
19			<input type="checkbox"/>	<input type="checkbox"/> Aug
20			<input type="checkbox"/>	<input type="checkbox"/> Sept
21			<input type="checkbox"/>	<input type="checkbox"/> Oct
22			<input type="checkbox"/>	<input type="checkbox"/> Nov
			<input type="checkbox"/>	<input type="checkbox"/> Dec

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

WILLIAM FIORINO  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



STEPHANIE HARRIS  
1 Main St  
GREER, RI, 12351

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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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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals 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>STEPHANIE HARRIS</b>	2 Social security number (SSN) *****8232	7 Name of employer RMLS	8 Employer identification number (EIN) <b>23-4232222</b>
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO</b>
9 Street address (including room or suite no.) <b>Sacfasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): <b>11</b>													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>									
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2C</b>	<b>2C</b>									

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>1E</b>												
<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>	<b>\$ 49.50</b>									
<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2C</b>	<b>2C</b>	

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

FE ANGELES  
1 Main St  
GREER, RI, 12351

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### Part I. Employee.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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### Part III. Covered Individuals, Lines 17-22

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**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)**

1 Name of employee FE ANGELES	2 Social security number (SSN) *****1978	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdfasd ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**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) 1E												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable) 2G	2G	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. 

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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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

KENNETH LAND  
1 Main St  
GREER, RI, 12351

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**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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>KENNETH LAND</b>	2 Social security number (SSN) *****0725	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E
15 Employee Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2D	2G	2G	2G	2G

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage							
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<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"/>
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"/>
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"/>
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"/>
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

 VOID CORRECTED

OMB No. 1545-2251

**2016**

VENKATA PAMARAJU  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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### Part III. Covered Individuals, Lines 17-22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 VOID       CORRECTED  
 ▶ Do not 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)**
**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 II Employee Offer of Coverage**

		Applicable Large Employer Member (Employer)											
1 Name of employee		2 Social security number (SSN) *****5393		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222							
3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342		13 Country and ZIP or foreign postal code AZ 23423							
4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	13 State or province 23423	Plan Start Month (Enter 2-digit number): 11							
14 Offer of Coverage (enter required code) 1E	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions) \$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G													

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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.

MARGARITA MOLINA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>MARGARITA MOLINA</b>	2 Social security number (SSN) *****4595	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
			13 Country and ZIP or foreign postal code 23423

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

VOID       CORRECTED

**2016**

DAVID HOFFARD  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 DAVID HOFFARD  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER  
 RI  
 5 State or province  
 6 County and ZIP or foreign postal code  
 12351

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not 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) ***** 6705	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdfasd ADFA	10 Contact telephone number 2342342342	11 City or town AJO
4 City or town	5 State or province RI	12 State or province AZ	13 Country and ZIP or foreign postal code 23423

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

ANDREW WILLIS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17-22

Part II I reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 ANDREW WILLIS

 ▶ Do not 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).

**Employer-Provided Health Insurance Offer and Coverage**

Safe Harbor and Other Relief (enter code, if applicable)

**Part II Employee Offer of Coverage**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 VOID

 CORRECTED

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DEJUANN MURRELL  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 DEJUANN MURRELL  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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) *****2751	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including room or suite no.)	9 Street address (including room or suite no.) Safdasdf ADFA		
4 City or town	5 State or province	6 County and ZIP or foreign postal code AJO	10 Contact telephone number 2342342342
GREER	RI	AZ	11 City or town AJO
12 State or province AZ			
13 Country and ZIP or foreign postal code 23423			

**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)	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2D	2G	2G	2G	2G	2G	2G	2G	2G

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

ALEXANDER BERINATO  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 VOID       CORRECTED  
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**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 II Employee Offer of Coverage**

1 Name of employee ALEXANDER BERINATO	2 Social security number (SSN) *****7518	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code 12351	11 City or town AJO	12 State or province AZ	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code 23423			

**Part III Covered Individuals**
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2C										

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Cat. No. 60705M

Form 1095-C (2016)

WILLIAM SEATON  
1 Main St  
GREER, RI, 12351

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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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**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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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BRIAN MANEKE  
1 Main St  
GREER, RI, 12351

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**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 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.  
**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>BRIAN MANEKE</b>	2 Social security number (SSN) *****6045	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Contribution (see instructions)	\$ 811.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

OMB No. 1545-2251

**2016**

Form **1095-C** (2016)

ROBERT FELCH  
1 Main St  
GREER, RI, 12351

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 ROBERT FELCH  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**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)	1E												
15 Employee Required Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

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**Applicable Large Employer Member (Employer)**

1 Name of employer	2 Social security number (SSN) *****6539	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	
1 Main St	11 City or town AJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
4 City or town GREER RI	5 State or province 12351	6 County and ZIP or foreign postal code AJO	

**Part III Covered Individuals**

	(a) Name of covered individual(s)	(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"/>

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

CHRISTOPHER MONK  
1 Main St  
GREER, RI, 12351

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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>CHRISTOPHER MONK</b>	2 Social security number (SSN) *****6040	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER RI</b>	5 State or province <b>12351</b>	6 County and ZIP or foreign postal code <b>AJO</b>
9 Street address (including room or suite no.) <b>Safdfasd ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Plan Start Month (Enter 2-digit number): 11													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2G	2G	2G	2G	2G	2G	2A	2A	2A	2A

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

DAVID GALE  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

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**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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- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has 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

**Part I Employee**  
 1 Name of employee  
**DAVID GALE**  
 ▶ Do not 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)
**Employer-Provided Health Insurance Offer and Coverage**

► Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****8075		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months 1E	Jan	Feb	Mar	Apr	May	June
15 Employee Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

RMS  
sdfasdfs ADFA  
AJO, AZ, 23423

KEVIN RUTROFF  
1 Main St  
GREER, RI, 12351

## 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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**1A.** Minimum 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.  
**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>KEVIN RUTROFF</b>	2 Social security number (SSN) *****5436	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number <b>2342342342</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2A	2A	2A	2A	2A	2A	2A	2A	2G	2G	2G

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

DAVID MORGAN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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CAROLE KLANG  
1 Main St  
GREER, RI, 12351

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 CAROLIE KLANG  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E	Plan Start Month (Enter 2-digit number): 11												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

 VOID

 CORRECTED

ANDREA NAVA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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 ANDREA NAVA	2 Social security number (SSN) *****2243	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ
13 Country and ZIP or foreign postal code 23423			

**Part II Employee Offer of Coverage**

14 Offer of Coverage (enter required code)	Plan Start Month (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2B	2B	2A								

**Part III Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

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17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

VOID

CORRECTED

JATIN TRIVEDI  
1 Main St  
GREER, RI, 12351

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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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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 Name of employee  
 JATIN TRIVEDI  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G	2G	2G	2B	2B	2A							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
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

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

 Form **1095-C** (2016)

MARY BRANNON  
1 Main St  
GREER, RI, 12351

## 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).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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>MARY BRANNON</b>	2 Social security number (SSN) *****3398	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14 Offer of Coverage (Enter required code)</b>	<b>1E</b>												
<b>15 Employee Required Contribution (see instructions)</b>	<b>\$</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 811.00</b>	<b>\$ 49.50</b>
<b>16 Section 4980H Safe Harbor and Other Relief (Enter code, if applicable)</b>		<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2G</b>	<b>2C</b>	<b>2C</b>

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>17</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>18</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>19</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>20</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>21</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>22</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)

MARCUS WATSON  
1 Main St  
GREER, RI, 12351

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**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (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>MARCUS WATSON</b>	2 Social security number (SSN) *****2719	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
9 Street address (including room or suite no.) <b>Safdasdf ADFA</b>	10 Contact telephone number 2342342342	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>
13 Country and ZIP or foreign postal code <b>23423</b>			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

GEOFFREY HART  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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Part 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  
**GEOFFREY HART**  
 ▶ Do not 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) *****4647		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
3 Street address (including apartment no.) 1 Main St		4 City or town GREER RI		5 State or province 12351		6 County and ZIP or foreign postal code AJO	
Plan Start Month (Enter 2-digit number): 11							
All 12 Months	Jan	Feb	Mar	Apr	May	June	July
14 Offer of Coverage (enter required code) 1E							
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G							

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

GILDA LOVKA  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by 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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### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

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**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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Part 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  
 GILDA LOVKA  
 Street address (including apartment no.)  
 1 Main St  
 City or town  
 GREER RI  
 State or province  
 12351

**Employer-Provided Health Insurance Offer and Coverage**  
 ▶ Do not 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)	1E	Plan Start Month (Enter 2-digit number): 11												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	\$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G													

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>											
18				<input type="checkbox"/>											
19				<input type="checkbox"/>											
20				<input type="checkbox"/>											
21				<input type="checkbox"/>											
22				<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 VOID       CORRECTED      **2016**

GARY GREEN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.

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**1095-C**  
 Form  
 Department of the Treasury  
 Internal Revenue Service

**Part I Employee**  
 1 Name of employee  
 GARY GREEN  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Part II Employee Offer of Coverage**

		2 Social security number (SSN) *****1457		7 Name of employer RMLS		8 Employer identification number (EIN) 23-4232222	
		3 Street address (including apartment no.) 1 Main St		9 Street address (including room or suite no.) Safdasdf ADFA		10 Contact telephone number 2342342342	
		4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423
<b>Part II Employee Offer of Coverage</b>							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June
1E							
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G						

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17					<input type="checkbox"/>											
18					<input type="checkbox"/>											
19					<input type="checkbox"/>											
20					<input type="checkbox"/>											
21					<input type="checkbox"/>											
22					<input type="checkbox"/>											

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

GARY SOMMER  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum 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

**Part I Employee**  
 1 Name of employee  
 GARY SOMMER  
 ▶ Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)
**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

**Employee**

1 Name of employee	2 Social security number (SSN) *****2501		7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222								
3 Street address (including apartment no.) 1 Main St	4 City or town GREER RI		5 State or province 12351	6 County and ZIP or foreign postal code AJO								
<b>Part II Employee Offer of Coverage</b>												
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E												
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G												

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
			Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

 Form **1095-C** (2016)

 VOID

 CORRECTED

OMB No. 1545-2251

**2016**

KEITH DEVERE  
1 Main St  
GREER, RI, 12351

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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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**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 KEITH DEVERE	2 Social security number (SSN) *****5426	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.) 1 Main St	4 City or town GREER	5 State or province RI	6 County and ZIP or foreign postal code 12351										
9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342	11 City or town AJJO	12 State or province AZ										
13 Country and ZIP or foreign postal code 23423	14 Offer of Coverage (Enter 2-digit number): 11												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	1E												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50	\$ 49.50
2G													

**Part II Employee Offer of Coverage**

All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1E												
\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
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**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage										
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17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

ZHENYING CHEN  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

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**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

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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  
 ZHENYING CHEN  
 3 Street address (including apartment no.)  
 1 Main St  
 4 City or town  
 GREER RI  
**Part II Employee Offer of Coverage**

1 Name of employee	2 Social security number (SSN) *****2476	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222										
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342											
1 Main St	11 City or town AJJO	12 State or province AZ	13 Country and ZIP or foreign postal code 23423										
4 City or town	5 State or province RI	6 County and ZIP or foreign postal code 12351											
<b>Plan Start Month</b> (Enter 2-digit number): 11													
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)	1H												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

**Part III Covered Individuals**

 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage
17		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
18		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
19		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
21		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
22		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

**Employer-Provided Health Insurance Offer and Coverage**

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**Applicable Large Employer Member (Employer)**

1 Name of employee	2 Social security number (SSN) *****2476	7 Name of employer RMLS
ZHENYING CHEN		
3 Street address (including apartment no.)	9 Street address (including room or suite no.) Safdasdf ADFA	10 Contact telephone number 2342342342
1 Main St	11 City or town AJJO	13 Country and ZIP or foreign postal code 23423
4 City or town	5 State or province RI	6 County and ZIP or foreign postal code 12351

Plan Start Month (Enter 2-digit number): 11													
14 Offer of Coverage	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Contribution (see instructions)	1H												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A

 VOID       CORRECTED       OMB No. 1545-2251

**2016**

DAVID CRAWFORD  
1 Main St  
GREER, RI, 12351

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**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (95% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
- 1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that continue Part III.

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for 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 <b>DAVID CRAWFORD</b>	2 Social security number (SSN) *****0293	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	6 County and ZIP or foreign postal code <b>12351</b>
11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	13 Country and ZIP or foreign postal code <b>23423</b>	
<b>Applicable Large Employer Member (Employer)</b>			
► Information about Form 1095-C and its separate instructions is at <a href="http://www.irs.gov/form1095c">www.irs.gov/form1095c</a> .			

**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)	1E												
15 Employee Required Contribution (see instructions)	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G												

**Part III Covered Individuals**If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. 

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2016)

JENNIFER WITHERS  
1 Main St  
GREER, RI, 12351

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

### Part I. Employee.

**Lines 1-6.** Part I, lines 1-6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7-13.** Part I, lines 7-13, reports information about your employer

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14-16.

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum 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>JENNIFER WITHERS</b>	2 Social security number (SSN) *****5740	7 Name of employer RMLS	8 Employer identification number (EIN) 23-4232222
3 Street address (including apartment no.) <b>1 Main St</b>	4 City or town <b>GREER</b>	5 State or province <b>RI</b>	9 Street address (including room or suite no.) Safdasdf ADFA
6 County and ZIP or foreign postal code <b>12351</b>	11 City or town <b>AJO</b>	12 State or province <b>AZ</b>	10 Contact telephone number 2342342342
13 Country and ZIP or foreign postal code <b>23423</b>			

**Applicable Large Employer Member (Employer)**

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 11											
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) <b>1E</b>													
15 Employee Required Contribution (see instructions) \$	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 811.00	\$ 49.50
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2G		2G	2G	2G	2G	2G	2G	2G	2G	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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2016)