Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Curtis Jacobson sr
1 Main St 1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Curtis Jacobson sr	*****1614

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number):

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Barbara Suhn
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Barbara Suhn	*****6836

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If 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.

Lisa Heigh
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Lisa Heigh	*****4315

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Lisa Duh
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Lisa Duh	*****7420

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

	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	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Cecil Averett
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Cecil Averett	*****1259

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Laurel Hortsch
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Laurel Hortsch	*****2094

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Vicki Papasadero
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Vicki Papasadero	*****5153

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Celess Zinda
1 Main St
GREER, NY, 74584

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ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Celess Zinda	*****5141

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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

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1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Roy Brower
1 Main St
GREER, NY, 74584

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ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Roy Brower	*****7383

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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Cat. No. 60705M

Form **1095-C** (2016)

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

Matthew Hampton
1 Main St
GREER, NY, 74584

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ACCORD, NY, 23423

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Internal Revenue Service

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Matthew Hampton	*****4876

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

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ASDFADFADFADF ADSFASDFADF	2342342340

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ACCORD	NY	23423

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Plan Start Month (Enter 2-digit number): 07

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Donovan Boell
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Donovan Boell	*****2110

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Ronald Zito
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Ronald Zito	*****5213

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

William Jemison
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
William Jemison	*****2984

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

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

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

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

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

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

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

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

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

Jean Baker
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jean Baker	*****0642

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Stephanie Mansheim
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Stephanie Mansheim	*****0464

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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Cat. No. 60705M

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1F. Minimum 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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Catherine Ridenour
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Catherine Ridenour	*****7919

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

	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	1A	1A	1A
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	2D	2D	2E	2E	2E

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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John Kovach
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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Department of the Treasury
Internal Revenue Service

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
John Kovach	*****9419

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

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Plan Start Month (Enter 2-digit number): 07

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

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Cat. No. 60705M

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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.

Timothy OBrien
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Timothy OBrien	*****4463

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Theodore Reid
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Theodore Reid	*****8067

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Constance Wadkins
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Constance Wadkins	*****0362

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

Part I. Employee.

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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.

Richard Hodges
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Richard Hodges	*****9110

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

	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	1A	1A
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	2D	2D	2D	2E	2E

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Patricia Zenger
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Patricia Zenger	*****6737

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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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 that your employer has 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.

Lisa Colling
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Lisa Colling	*****7627

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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

Part I. Employee.

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

Benjamin Rowe
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Benjamin Rowe	*****6754

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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Cat. No. 60705M

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

Part III. Covered Individuals, Lines 17-22

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

Kyle Mann
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Kyle Mann	*****6745

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Scott Harder
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Scott Harder	*****5655

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

April Siebenaler
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
April Siebenaler	*****8691

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a “0.00” for the amount.
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Part III. Covered Individuals, Lines 17-22

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

Cathie Roberts
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Cathie Roberts	*****9907

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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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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Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

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

Sarah Wyllie
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Sarah Wyllie	*****1839

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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

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

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

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

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

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

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

Glen Marcusen
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Glen Marcusen	*****0662

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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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.

Olena Turula
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Olena Turula	*****8293

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

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Part III. Covered Individuals, Lines 17-22

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

Nancy Erz
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Nancy Erz	*****1503

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Kellie Hauger
1 Main St
GREER, NY, 74584

ORGON
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ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Kellie Hauger	*****5972

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Shannon LaMonica
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Shannon LaMonica	*****4088

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

Robert Draughon
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Robert Draughon	*****7720

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Patrick Moten
1 Main St
GREER, NY, 74584

ORGON
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ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Patrick Moten	*****4794

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Daniel Kromer
1 Main St
GREER, NY, 74584

ORGON
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ACCORD, NY, 23423

that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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600117

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

Employer-Provided Health Insurance Offer and Coverage

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

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OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Daniel Kromer	*****4634

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Kari Meyer
1 Main St
GREER, NY, 74584

ORGON
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ACCORD, NY, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Kari Meyer	*****6975

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
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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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Cat. No. 60705M

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Part III. Covered Individuals, Lines 17-22

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

Jenny DeGroot
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jenny DeGroot	*****3270

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Lorraine Berard
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Lorraine Berard	*****3571

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Cole Hawkey
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Cole Hawkey	*****7099

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
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Part III. Covered Individuals, Lines 17-22

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

Eleanor Malin
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Eleanor Malin	*****3117

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

William Edinger
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
William Edinger	*****3461

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

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

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

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

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

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

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

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

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

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Part III. Covered Individuals, Lines 17-22

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

Douglas Towsley
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Douglas Towsley	*****5328

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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Part I. Employee.

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

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

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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.

Christine Bachman
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Christine Bachman	*****6858

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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Cat. No. 60705M

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

Part III. Covered Individuals, Lines 17-22

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

Kate McLean
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Kate McLean	*****4290

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Derald Mathies
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

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☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Derald Mathies	*****7961

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

Enrique Vargas
1 Main St
GREER, NY, 74584

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Enrique Vargas	*****0361

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Rose Moore
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Rose Moore	*****4677

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Robin Laughlin
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Robin Laughlin	*****0144

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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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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Karen Cornell
1 Main St
GREER, NY, 74584

ORGON
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ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Karen Cornell	*****6763

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

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1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has 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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Richard Walker
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Richard Walker	*****3940

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

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

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
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17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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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.

Julia Walz
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Julia Walz	*****2257

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III. Covered Individuals, Lines 17-22

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

Amy Padilla
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Amy Padilla	*****0207

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Jody VanRiper
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
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☐ VOID
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OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Jody VanRiper	*****2742

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

Instructions for Recipient

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Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Ellen Wyoming
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

600117

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

Employer-Provided Health Insurance Offer and Coverage

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

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Ellen Wyoming	*****6983

3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
1 Main St	GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

Form **1095-C** (2016)

Instructions for Recipient

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

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

Part I. Employee.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Brian Evans
1 Main St
GREER, NY, 74584

ORGON
ASDFADFADFADF ADSFASDFADF
ACCORD, NY, 23423

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

Part III. Covered Individuals, Lines 17-22

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

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
Brian Evans	*****4047

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

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GREER	NY	74584

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ORGON	23-2233333

9 Street address (including room or suite no.)	10 Contact telephone number
ASDFADFADFADF ADSFASDFADF	2342342340

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ACCORD	NY	23423

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 07

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

Part III Covered Individuals

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

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

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

Cat. No. 60705M

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