Form 1095-C
Department of the Treasury
Internal Revenue Service

Part I Employee

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

VOID
 OMB No. 1545-2251
 □ CORRECTED
 ② 18

Applicable Large Employer Member (Employer)

► Go to www.irs.gov/Form1095C for instructions and the latest information.

Name of employee (first name, middle initial, last name) Social secu				Social security number (SSN)			7 Name of employer						8 8	8 Employer identification number (EIN)						
James E Thompson					Brad			Emily						1	Mary					
3 Street address (including apartment no.)						9 Street address (including room or suite no.)						10 (10 Contact telephone number							
Taylor					Jim					1	Marcos									
4 (City or town		5 State or provin	ce	6 Country	y and ZIP or foreign po	stal code 1	11 City or tov	wn		12 St	ate or pro	vince		13 (Country and	d ZIP or fo	reign post	al code	
N	Mark		Gaven		Kyle			Cedric				an				12				
Pa	rt II Emp	loyee Of	fer of Covera	age				Plan Sta	rt Mo	nth (ente	er 2-di	git num	ber):					-	<u>@</u>	
		All 12 Month	s Jan	Feb	Mar	Apr	May	June		July	P	Aug	Sep	ot	Oct		Nov		Dec	
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Requ Cont	Employee uired tribution (see uctions)	\$	\$ 2019-01-157	7\$ 5200:9402005070	\$ 0200 9 -03045	7: © 02001:9014005 06S 02	DO9:050455	E \$ 0200:94060	05 0'6'\$02 0):199-1070-1- 5 77	60 3820 19	9 000-5016 9	&20 :199-10	901-5760 3 80	X0:0900 0)1 5T(\$)2 (0)	1 9 9109 0 40	07:00		-000:00:00
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Pa		ered Indiv		red coverage	. check the	box and enter th	ne informa	ation for e	ach inc	dividual e	enrolle	d in cov	erage.	includin	a the e	mplove	ee.	07:00)	
If Employer provided self-insured coverage, check the box and enter the information (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (d) Covere								1												
		e, middle initial, last name		(b) 331101	Outer Till	TIN is not available)	all 12 month		Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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