

VOID CORRECTED

OMB No. 1545-2251

2025

Form 1095-C

**Employer
Provided
Health
Insurance
Offer and
Coverage**
Part I APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

Plan Start Mo. (enter 2-digit no.):	Employee Offer of Coverage		Employee's Age on January 1	
	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	17 ZIP code
All 12 Months	\$			
Jan	\$			
Feb	\$			
Mar	\$			
Apr	\$			
May	\$			
June	\$			
July	\$			
Aug	\$			
Sept	\$			
Oct	\$			
Nov	\$			
Dec	\$			

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

Department of the Treasury -- IRS

Part II APPLICABLE LARGE EMPLOYER'S First name, middle name, last name, street address (including apartment no.), city or town, state or province, country, ZIP or foreign postal code

EMPLOYEE'S identification number (EIN)

EMPLOYEE'S social security number (SSN)

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 mos.	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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