

Department of the Treasury
Internal Revenue Service

OMB No. 1545-2252

☐ VOID
☐ CORRECTED

2015

* Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.**Part I Responsible Individual**

1 Name of responsible individual James J Small	2 Social security number (SSN) ***-**-4437	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.) PO BOX 27774	5 City or town SANTA ANA	6 State or province CA
		7 Country and ZIP or foreign postal code 92799

8 Enter letter identifying Origin of the Policy (see instructions for codes):

☐ A ☒ B

9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable

Part II Employer Sponsored Coverage (see instructions)

10 Employer name AUTOMOBILE CLUB OF SOUTHERN CALIFORNIA	11 Employer identification number (EIN) *****4585
12 Street address (including room or suite no.) 3333 FAIRVIEW RD STE A154	13 City or town COSTA MESA
	14 State or province CA
	15 Country and ZIP or foreign postal code 92626

Part III Issuer or Other Coverage Provider (see instructions)

16 Name Kaiser Foundation Health Plan	17 Employer identification number (EIN) 941340523	18 Contact telephone number 844-477-0450
19 Street address (including room or suite no.) One Kaiser Plaza, 15L	20 City or town Oakland	21 State or province CA
		22 Country and ZIP or foreign postal code United States of America US 94612

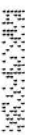
Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 JAMES J SMALL	***-**-4437		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Cat. No. 50704B

Form 1095-B (2015)



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Form
1095-B

Health Coverage

☐ VOID

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Department of the Treasury
Internal Revenue Service

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2015

Part I Responsible Individual

1 Name of responsible individual JAMES J SMALL	2 Social security number (SSN) *****4437	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.) PO BOX 9263	5 City or town REDLANDS	6 State or province CA
		7 Country and ZIP or foreign postal code 92375

8 Enter letter identifying Origin of the Policy (see instructions for codes): **D**

Part II Employer Sponsored Coverage (see instructions)

10 Employer name	11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town
	14 State or province
	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY	17 Employer identification number (EIN) 95-4331852	18 Contact telephone number 1-(800)-333-0912
19 Street address (including room or suite no.) 120 MONUMENT CIRCLE	20 City or town INDIANAPOLIS	21 State or province IN
		22 Country and ZIP or foreign postal code 46204-4903

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
JAMES J SMALL	*****4437		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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