

Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095C for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251 500118

2018

Part I Employee

1 Name of employee (first name, middle initial, last name)
AWAIS SULTAN

3 Street address (including apartment no.)
1157 W VERNON PARK PL

4 City or town
CHICAGO

5 State or province
IL

6 Country and ZIP or foreign postal code
60607

Applicable Large Employer Member (Employer)

7 Name of employer
US BANK NATIONAL ASSOCIATION

9 Street address (including room or suite no.)
4000 WEST BROADWAY

11 City or town
ROBBINSDALE

12 State or province
MN

8 Employer identification number (EIN)
31-0841368

10 Contact telephone number
800-806-7009

13 Country and ZIP or foreign postal code
55422-2212

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number): **01**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83	\$ 67.83
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	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) 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 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	AWAIS SULTAN	***-**-6504			X	X	X	X	X	X	X	X	X	X	X	X
18	SALIHA AWAIS	***-**-8460			X	X	X	X	X	X	X	X	X	X	X	X
19	DANIA A SULTAN	***-**-6714			X	X	X	X	X	X	X	X	X	X	X	X
20	MEKAEL J SULTAN	***-**-6256			X	X	X	X	X	X	X	X	X	X	X	X
21	ZARIA S SULTAN	***-**-4558														X

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

Cat No 60705M

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Name of employee (first name, middle initial, last name)
AWAIS SULTAN

Social security number (SSN)
*****-**-6504**

Part III Covered Individuals - Continuation Sheet

	(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 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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