

**Employer-Provided Health Insurance Offer and Coverage**

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095C](https://www.irs.gov/Form1095C) for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                     |                                |  | Applicable Large Employer Member (Employer)    |                 |      |  |  |   |     |     |     |  |
|---|---------------|---------------------|--------------------------------|--|--|-----------------|------|--|--|---|-----|-----|-----|--|
| 1 Name of employee (first name, middle initial, last name)                |               |                     | 2 Social security number (SSN) |  | 7 Name of employer                             |                 |      |  | 8 Employer identification number (EIN) |   |     |     |     |  |
| 3 Street address (including apartment no.)                                |               |                     |                                |  | 9 Street address (including room or suite no.) |                 |      |  | 10 Contact telephone number            |   |     |     |     |  |
| 4 City or town  |               | 5 State or province |                                | 6 Country and ZIP or foreign postal code |  | 11 City or town |      | 12 State or province                     |  | 13 Country and ZIP or foreign postal code |     |     |     |  |
| Part II Employee Offer of Coverage  |               |                     |                                | Employee's Age on January 1              |  |                 |      | 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)                                |               |                     |                                |  |  |                 |      |  |  |   |     |     |     |  |
| 15 Employee Required Contribution (see instructions)                      | \$            | \$                  | \$                             | \$                                       | \$   | \$              | \$   | \$                                       | \$                                     | \$  | \$  | \$  | \$  |  |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) |               |                     |                                |  |  |                 |      |  |  |   |     |     |     |  |
| 17 ZIP Code   |               |                     |                                |  |  |                 |      |  |  |   |     |     |     |  |