

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

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 | | | | | | | | | | | | | | |