ELVIRA L BAIRES 1171 Highway 76 Chatsworth, GA 30705-6366

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Depar	tme	nt d	of th	ne T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

internal Revenue Ser	rvice		GO to www.	irs.gov/ron	11110950 101 111	Structions ar	iu trie iatest ii	normation.				_ `				
Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Memb	er (Employ	/er)				
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)			
ELVIRA		L BAIRE	ES		XXX-XX-9	597	Campbell F	Printing Con	npany, Inc.			58136	5997			
3 Street address (in	ncluding apartm	ent no.)		'			9 Street address (including room or suite no.)					10 Contact telephone number				
1171 Highway	, 76						2055 Cleveland Hwy					706259	3344			
4 City or town	5	State or provi	ince	6 Countr	y and ZIP or forei	or foreign postal code 11 City or town 12 State or province					13 Cou	13 Country and ZIP or foreign postal code				
Chatsworth							705-6366 Dalton GA			US 3	30721					
Part II Emp	oloyee Offe	r of Cove	rage	•	Employee ³	s Age on	January 1		Plan Star	rt Month (er	nter 2-digit n	umber):	06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2H			
17 ZIP Code													1005.0			

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Obdulia Barcenas 410 Martha Sue Dr Apt C Dalton, GA 30721

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Form	1	J	J	U
Depar	tment	t of th	e Trea	asury
Interna	al Rev	enue	Servi	CA

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form1	1095C for ins	tructions and	a the latest into	ormation.			l			
Part I Emp	oloyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	/ee (first name, r	middle initial, last	name)	2 Social se	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)	
Obdulia		Barcen	as	X	(XX-XX-43	52	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	including apartm	nent no.)					9 Street address	(including room	10 Contac	10 Contact telephone number				
410 Martha S	ue Dr Apt C						2055 Clevela	and Hwy		7062593344				
4 City or town		5 State or province	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Country	13 Country and ZIP or foreign postal		
Dalton		GA		US 3072	US 30721				GA		US 307	721		
Part II Emp	oloyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit num	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	S 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													205.0	

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Cat. No. 60705M

Form 1095-C (2024)

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18												Aug	Зері			
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Socorro Bejarano 220 S Grimes St Dalton, GA 30721

Form 1095-C	
Department of the Treasury	
Internal Devenue Convice	

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Sei	rvice		GO LO WWW.II	s.gov/Formi	1095C IOI IIISI	il uctions and	a the latest line	Jimauon.					-	
Part I Emp	oloyee						Ap	plicable La	rge Employ	er Membe	r (Employe	r)		
1 Name of employ	ee (first name, r	middle initial, last i	name)	2 Social se	ecurity number (SSN)	7 Name of emplo	oyer	-		8 Emplo	yer identificatio	n number (EIN)	
Socorro		Bejaran	0	X	XX-XX-651	14	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (in	ncluding apartn	nent no.)				!	9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber	
220 S Grimes	St]:	2055 Clevela	and Hwy				7062593344		
4 City or town		5 State or provinc	ce	6 Country a	nd ZIP or foreign	postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
Dalton		GA		US 3072	21	[1	Dalton		GA		US 30	721		
Part II Emp	oloyee Offe	er of Covera	ge	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	06	
	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	
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code									L- 00705M				005 € (2004)	

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Cat. No. 60705M

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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Arthur D Biles 1575 Threadmill Road Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	rge Employ	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, r	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Arthur		D Biles		×	(XX-XX-451	11	Campbell Printing Company, Inc.					581366997			
3 Street address (i	ncluding apartm	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
1575 Threadn	nill Road						2055 Clevela	and Hwy				70625933	44		
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton		GA		US 3072	20		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00 <i>\{</i>	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Kera L Brewer 29 June Lane Ringgold, GA 30736

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee							Ap	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name,	midd	le initial, last ı	name)	2 Social s	security number	(SSN)	7 Name of employer					yer identificatio	n number (EIN)		
Kera		L	Brewer			XXX-XX-284	47	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartr	ment	no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
29 June Lane								2055 Clevel	and Hwy				7062593344			
4 City or town		5 Sta	ate or provinc	e	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code		
Ringgold			US 307	36		Dalton		GA		US 30	721					
	loyee Off	er o	f Covera	ge	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
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)	\$	\$	135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00)\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code														005 0 (200)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Kera XXX-XX-2847 18 **Brewer** 19 20 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Larry R Brewer 1005 Glisson Dr Tunnel Hill, GA 30755

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www.ir	s.gov/Form	1095C for ins	tructions and	I the latest info	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	r (Employe	er)			
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of employer					8 Employer identification number (EII)			
Larry		R Brewer		X	XXX-XX-4757 Campbell Printing Con				pany, Inc.			581366997			
3 Street address (i	ncluding apartm	nent no.)				٤	9 Street address (including room or suite no.)					10 Contact telephone number			
1005 Glisson	1005 Glisson Dr											70625933	44		
4 City or town	6 Country a	and ZIP or foreigr	n postal code 1	1 City or town		12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code					
Tunnel Hill	US 307!	55	[Dalton		GA		US 30)721						
Part II Emp	oloyee Offe	er of Covera	age	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	ter 2-digit nu	mber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													005 0 (222		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	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) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																	
	(a) Name of First name, n			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Larry	R	Brewer	XXX-XX-4757			\times	\times	\times	\times	X	X	X	X	\times	\times	\times	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Tony L Bryson 301 Frontier Trail Nw Dalton, GA 30721

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OMB No. 1545-2251

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2024

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Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	er (Employe	r)			
1 Name of employ	/ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)		
Tony		L Bryson) X	(XX-XX-692	28	Campbell Pr	inting Com		5813669	97				
3 Street address (i	including apartm	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
301 Frontier T	01 Frontier Trail Nw							2055 Cleveland Hwy					344		
4 City or town							nd ZIP or foreign postal code 11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
Dalton GA US 30721							Dalton GA					721			
Part II Employee Offer of Coverage US 30721 Employee's Age							anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code															

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Cat. No. 60705M

Form 1095-C (2024)

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I rt III Covere			red coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Tony	L	Bryson	XXX-XX-6928							Iviay	X	X	X	Х	X	X	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

NATASHA M BURKE 158 Hideaway Dr Tunnel Hill, GA 30755-6235

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OMB No. 1545-2251

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2024

Internal Revenue Ser	vice		GO TO WWW.	.irs.gov/For	m 1095C for in	structions ar	ia the latest ii	ntormation.							
Part I Emp	loyee						А	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)			
1 Name of employe	ee (first name, r	middle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
NATASHA		M BURK	E		XXX-XX-8	574	Campbell Printing Company, Inc.					58136	6997		
3 Street address (in	Street address (including apartment no.)							ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
158 Hideaway	Dr						2055 Cleve	eland Hwy				706259	3344		
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town	· · · · · · · · · · · · · · · · · · ·	12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code		
Tunnel Hill	(GA		US 30	755-6235		Dalton		GA		US :	30721			
Part II Emp	loyee Offe	er of Cover	rage		Employee ³	s Age on	January 1		Plan Sta	rt Month (e	nter 2-digit r	iumber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2A	2A		
17 ZIP Code													1005.0		

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Cat. No. 60705M

Form 1095-C (2024)

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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

YADIRA CABRERA 1003 Shelia Ct NE Dalton, GA 30721-8518

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	oloyee						Aı	oplicable La	arge Emplo	yer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, r	niddle initial, las	st name)	2 Social	security number	(SSN)	7 Name of emp	loyer			8 E	mployer identifica	tion number (EIN)
YADIRA	1	CABR	ERA		XXX-XX-02	271	Campbell Printing Company, Inc.					581366	997
3 Street address (i	ncluding apartm	nent no.)					9 Street addres	s (including roor	n or suite no.)		10 C	ontact telephone	number
1003 Shelia C	t NE						2055 Cleve	land Hwy				706259	3344
4 City or town	5	5 State or provi	nce	6 Country	y and ZIP or foreig	n postal code	11 City or town		12 State or pro	ovince	13 Co	ountry and ZIP or t	oreign postal code
Dalton	-	GA		US 30	721-8518		Dalton		GA		US	30721	
Part II Emp	oloyee Offe	er of Cover	age		Employee'	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit	number):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D
17 ZIP Code													1005.0

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Reynaldo Calderon Vigil 812 Red Clay, APT 2 Dalton, GA 30721

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	vice		Go to www.i	rs.gov/Form	1095C for inst	tructions an	d the latest inf	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Reynaldo		Caldero	n Vigil	>	(XX-XX-560)9	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartme	ent no.)		'			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
812 Red Clay	APT 2						2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	e	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton		GΑ		US 307	21		Dalton		GA		US 30	721			
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	2-digit number):			
All 12 Months Jan Feb M					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)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code			at Matica										00E C (200		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Brian L Campbell 431 Caldwell Rd Se Cleveland, TN 37323

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

2024

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Brian Campbell XXX-XX-1610 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 431 Caldwell Rd Se 2055 Cleveland Hwv 7062593344 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 Cleveland ΤN US 37323 Dalton GA US 30721 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 06 All 12 Months Feb Oct Dec Jan Mar Apr May June July Sept Nov 14 Offer of Coverage (enter 1E required code) 15 Employee Required Contribution (see 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (e) Months of coverage (b) SSN or other TIN (d) Covered (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Aug Jan Feb Mar Apr May June July Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Campbell XXX-XX-1610 18 Brian 19 20 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Sonya L Campbell 431 Caldwell Rd Cleveland, TN 37323

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Departi	ment of the	Treasury
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CORRECTED

VOID

OMB No. 1545-2251

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2024

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for insi	tructions and	a the latest int								
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social se	ecurity number ((SSN)	7 Name of employer					yer identificatio	n number (EIN)		
Sonya		L Campb	ell	X	(XX-XX-14 ⁴	17	Campbell Printing Company, Inc.					581366997			
3 Street address (i	ncluding apartm	ent no.)		•			9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
431 Caldwell	Rd						2055 Clevel	and Hwy				7062593344			
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Cleveland	-	TN		US 3732	23		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
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Pa	Irt III Covere			ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Sonya	L	Campbell	XXX-XX-1447	,		X	×	X	X	×	×	X	X	Х	×	×	\boxtimes
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Form 1095-C (2024)

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Timothy E Campbell 4278 Country Way Cohutta, GA 30710

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)	
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)
Timothy		E Cample	pell		XXX-XX-666	67	Campbell Pr	inting Com	pany, Inc.			5813669	97
3 Street address (in	ncluding apartr	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber
4278 Country	Way]:	2055 Clevela	and Hwy				70625933	344
4 City or town		5 State or provir	nce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code
Cohutta		GA		US 307	10		Dalton		GA		US 30	721	
Part II Emp	loyee Off	er of Cover	age	E	Employee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
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Cat. No. 60705M

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- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

30

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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|Ε Campbell XXX-XX-6667 18 Timothy \times \times \times \times \times \times |X| $|\times|$ X $|\times|$ \times 19 Campbell XXX-XX-7728 Theresa \times \times \times \times \times \times \times |X||X||X||X||X|G Campbell XXX-XX-5057 Austin 21 22 23 24 25 26 27 28 29

Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Timothy K Campbell 1504 Old Hwy 411 Chatsworth, GA 30705

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of employer				8 Emplo	8 Employer identification number (EIN)		
Timothy		K Campb	ell)	XX-XX-884	45	Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	ict telephone nu	mber	
1504 Old Hwy	/ 411						2055 Clevela	and Hwy				70625933	344	
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code	
Chatsworth	(GA		US 3070	05		Dalton		GA		US 30	721		
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													005 0 2	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times |X| \times |X| \times X \times \times |X|Campbell Κ XXX-XX-8845 18 Timothy \times \times X |X| $|\times|$ \times |X|X $|\times|$ \times |X|19 Mikaela Campbell XXX-XX-5391 \times \times \times \times \times \times \times \times |X||X||X||X|Campbell James XXX-XX-9928 X |X||X||X| \times |X||X|X |X||X||X||X|Campbell XXX-XX-0610 Alayne M \times X |X|X |X|Α Campbell XXX-XX-4144 Jeremiah 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Kimberley A Cannon Po Box 2329 Chatsworth, GA 30705

Form	1	U	9	5	-	C
Depar	tme	ent	of th	ne T	rea	sury
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17 ZIP Code

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

2024

Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Kimberley Α Cannon XXX-XX-8033 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2055 Cleveland Hwv 7062593344 Po Box 2329 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 GΑ Chatsworth US 30705 Dalton GA US 30721 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 06 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1E required code) 15 Employee Required Contribution (see 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C code, if applicable)

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere	ed Indi oyer pro	viduals vided self-insur	red coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of (First name, m	covered ir iddle initia	ndividual(s) ıl, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Kimberley	A	Cannon	XXX-XX-8033	,		X	X	X	X	×	X	×	X	X	X	X	X
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

JAIME CASTRUITA LEDESMA 171 Dead End Rd SE, Lot Bb Dalton, GA 30721-5800

Form	<u> 10</u>	95	-C
Depar	tment	of the Tr	reasury

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	rvice		GO to www	.irs.gov/For	m 1095C for in	structions an	ia the latest ir	ntormation.						
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employe	vee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 En	8 Employer identification number (EIN)		
JAIME		CAST	RUITA LEDE	:SN	XXX-XX-30	086	Campbell F	Printing Com	npany, Inc.			581366	997	
3 Street address (in	including apartr	ment no.)					9 Street addre	ss (including roo	m or suite no.)		10 Cd	ntact telephone	number	
171 Dead End	d Rd SE Lo	t Bb					2055 Cleve	eland Hwy				706259	3344	
4 City or town		5 State or provi	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP or	oreign postal code	
Dalton		GA		US 30	721-5800		Dalton		GA		US	30721		
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee ³	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit r	number):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2A	2A	2A	
17 ZIP Code													1005.0	

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

Cat. No. 60705M

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Joshua Chapman 1330 Coogler Rd Dalton, GA 30721

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Departr	nent of	the Tre	easury
Internal	Reveni	ie Serv	rice

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Se	rvice		GO to www.ii	s.gov/rorm	1095C for ins	tructions and	tne latest int	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	yer Membe	er (Employe	er)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social se	ecurity number	(SSN)	7 Name of emplo	oyer	8 Empl	8 Employer identification number (E					
Joshua		Chapm	an	XXX-XX-4356			Campbell Pr	inting Com		581366997					
3 Street address (i	ncluding apartm	ent no.)					9 Street address	(including room	n or suite no.)		10 Cont	act telephone nu	mber		
1330 Coogler	Rd]:	2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	се	6 Country a	nd ZIP or foreigr	n postal code 1	1 City or town		12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code		
Dalton		GA		US 3072	21		Dalton		GA		US 30	US 30721			
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (en	ter 2-digit nu	r 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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

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

Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Maria D Chavarria Fraire 101 Pamala St Dalton, GA 30720

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Form U	<i>)</i> 95-	'U
Department	of the Tre	asury
Internal Rev	anua San	rica

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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Part I Emp	oloyee							Ap	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name,	middle ir	nitial, last n	ame)	2 Social s	security number ((SSN)	7 Name of emp	8 Emplo	B Employer identification number (EIN)						
Maria		$D \mid C$	Chavarri	ia Fraire		XXX-XX-085	57	Campbell P	rinting Com		581366997					
3 Street address (in)					9 Street addres	s (including room	n or suite no.)		10 Conta	10 Contact telephone number					
101 Pamala St									and Hwy				7062593344			
4 City or town 5 State or province					6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal coo			
Dalton			US 307	20		Dalton		GA		US 30	US 30721					
Part II Emp	oloyee Off	er of (Coveraç	ge	E	Employee's	Age on J	January 1		Plan Start	Month (ent	er 2-digit nun	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)			1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 1	35.00 \$	3 135.00 \$	135.00	\$ 135.00	\$ 135.00)\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	S 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2	2H	2H	2H	2H	2H	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code										I- 00705M				005 € (0004		

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere			d coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of co			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

WILLIAM CLURE 229 GRYDER RD CHATSWORTH, GA 30705

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Form	I U95-	-U
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Internal	Rovenue Sen	/ica

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sel	rvice		GO to www.	is.gov/roi	<i>111109</i> 50 101 111	Structions an	iu tile latest li	nomation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	yer)			
1 Name of employ	ree (first name,	middle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
WILLIAM		CLUR	E		XXX-XX-0	Campbell Printing Company, Inc.						58136	6997		
3 Street address (i	ncluding apartr	ment no.)		'			9 Street address (including room or suite no.)					10 Contact telephone number			
229 GRYDER	RD							eland Hwy				7062593344			
4 City or town		5 State or provi	nce	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Cou	untry and ZIP or	foreign postal code		
CHATSWOR1	ГН	GA		US 30	705		Dalton		GA		US 3	30721			
Part II Emp	oloyee Off	er of Cover	age		Employee ³	s Age on J	lanuary 1		Plan Star	rt Month (er	nter 2-digit n	umber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	6	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2A	2A		
17 ZIP Code			A st Nation										1005 C (222)		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Gary S Coker 142 Woody Pond Way Dalton, GA 30721

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Depar	tme	nt o	of th	e T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.								
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)				
1 Name of employ	ee (first name, r	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)			
Gary		S Coker)	(XX-XX-13 <i>ϵ</i>	X-XX-1363 Campbell Printing Company, Inc.						5813669	97			
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
142 Woody Po	ond Way						2055 Clevela	and Hwy				7062593344				
4 City or town		State or province	ce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code			
Dalton		GA		US 30721			Dalton		GA		US 30	721				
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06			
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code													005 0			

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

John Collette 2018 Clematis Dr Hixson, TN 37343

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Form	1	J	J	U
Depar	tment	t of th	e Trea	asury
Interna	al Rev	enue	Servi	CA

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.							
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
John		Collette)	>	XXX-XX-0960 Campbell Printing Company, Inc.							5813669	97		
3 Street address (in	ncluding apartme	ent no.)		_			9 Street address	(including room	10 Conta	10 Contact telephone number					
2018 Clematis	s Dr]:	2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	ce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Hixson	т	N		US 373	43		Dalton		GA		US 30	721			
Part II Emp	loyee Offer	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													205. 2		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

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Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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	(a) Nam First nam	ne of covered in ne, middle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	John		Collette	XXX-XX-0960			X	\times	\times	X	X	X	X	X	X	X	\times	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jerry W Cross Jr Po Box 2022 Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest inform								ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Jerry	\	W Cross)	(XX-XX-27 <i>6</i>	67	Campbell Printing Company, Inc.					5813669	97		
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number					
Po Box 2022							2055 Cleveland Hwy					7062593344			
4 City or town					and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal code			
Chatsworth GA				US 3070	05		Dalton		GA		US 30	US 30721			
Part II Emp	loyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	-digit number): 06			
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													005 0 200		

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

Cat. No. 60705M

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Cross XXX-XX-2767 18 W Jerry 19 20 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

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MICHAEL S DEAN 312 SILVERS RD CHATSWORTH, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	loyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, i	middle initial, las	st name)	2 Social	I security number	r (SSN)	7 Name of emp	oloyer			8 Ei	nployer identifica	ation number (EIN)		
MICHAEL		S DEAN			XXX-XX-7805			Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartn	nent no.)					9 Street addres	ss (including roor	10 C	ontact telephone	number				
312 SILVERS	RD						2055 Cleve	land Hwy				706259	3344		
4 City or town 5 State or province				6 Country	y and ZIP or foreig	gn postal code	11 City or town		12 State or pro	ovince	13 Cd	13 Country and ZIP or foreign postal code			
CHATSWORTH GA				US 30	US 30705				GA		US	US 30721			
Part II Emp	loyee Offe	er of Cover	age	'	Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit	number):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2A	2A	2A	2A	2A		
17 ZIP Code													1005.0		

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Cat. No. 60705M

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

William J Deere 7 Tramore Ct Cartersville, GA 30120

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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VOID

OMB No. 1545-2251

2024

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) William Deere XXX-XX-2553 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 7 Tramore Ct 2055 Cleveland Hwv 7062593344 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 GΑ Cartersville US 30120 Dalton GA US 30721 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 06 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1E required code) 15 Employee Required Contribution (see 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 125.00\$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2H 2H 2H 2H 2H 2H 2H 2H code, if applicable) 2H 2H 2H 2H 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Larry E Dent II 780 Wood Grove Circle Hixson, TN 37343

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name, i	middle initial, last	: name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	on number (EIN)		
Larry		E Dent			XXX-XX-764	47	Campbell Pr	pany, Inc.		5813669	97				
3 Street address (in	ncluding apartn	nent no.)					9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
780 Wood Gro	ove Circle					1:	2055 Clevela	and Hwy				70625933	344		
4 City or town	City or town 5 State or province				and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal of			
Hixson	ixson TN				US 37343				GA		US 30	US 30721			
Part II Emp	loyee Offe	er of Covera	age	, E	Employee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C 2C			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C			
17 ZIP Code	7 ZIP Code												205.0		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	irt III C	overed In Employer p	div rov	iduals ided self-insu	ıred c	coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Na First na	ame of covered ame, middle in	l ind tial,	lividual(s) last name		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Charles T Duncan 175 Relic Way Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	vice		Go to www.ii	s.gov/Form	<i>1095C</i> for inst	tructions and	d the latest inf	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
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3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
175 Relic Way							2055 Clevela	and Hwy				7062593344			
4 City or town 5 State or province 6 Country and ZIP or foreign post												ry and ZIP or fore	eign postal code		
Dalton GA US 30721							Dalton		GA		US 30	721			
Part II Employee Offer of Coverage Employee's Age							anuary 1		Plan Start	Month (ent	er 2-digit nur	?-digit number): 06			
All 12 Months Jan Feb Mar Apr N							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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\</i>	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code									I- 00705M				005 € (2004)		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Lamar Dunn 231 Doctor Johnson Rd Crandall, GA 30711

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	vice		Go to www.ii	rs.gov/Form	<i>1095C</i> for inst	tructions and	d the latest inf	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number (SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Lamar		Dunn		\ \ \ \	(XX-XX-908	32	Campbell Pr	inting Com		58136699	97				
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
231 Doctor Johnson Rd							2055 Clevela	and Hwy				7062593344			
4 City or town 5 State or province 6 Country and ZIP or foreign posta							11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code		
Crandall GA US 30711							Dalton		GA		US 30	721			
Part II Employee Offer of Coverage Employee's Age							anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
All 12 Months Jan Feb Mar Apr							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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\</i>	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code			at Nation and						- 00705M				005 € (0004)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

JOSEPH DURHAM 2905 REBECCA CIRCLE ROCKY FACE, GA 30740

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Ser	vice		GO LO WWW	.ii s.gov/roi i	1110930 101 111	structions and	u tile latest lill	ormation.			1					
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)				
1 Name of employe	ee (first name, r	middle initial, last	t name)	2 Social	security number	r (SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)			
JOSEPH		DURH	AM		XXX-XX-27	' 63	Campbell Pr	rinting Com	pany, Inc.			5813669	97			
3 Street address (in	ncluding apartn	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
2905 REBECO	CA CIRCLE	Ξ					2055 Clevela	and Hwy				7062593344				
4 City or town		5 State or provin	ice	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal code				
ROCKY FACE	<u> </u>	GA		US 30	US 30740 Dalton GA					US 30721						
Part II Emp	loyee Offe	er of Cover	age		Employee'	s Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	\$ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2C	2C	2C	2C	2C	2C	2C	2C			
17 ZIP Code			And Notice on						2070514				00F C (200)			

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

Cat. No. 60705M

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- 1Z. Reserved for future use.

Pa	Irt III Covere	ed Individuals yer provided self-insu	ured coverage, check the	ne box and enter th	ne information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of c	overed individual(s) ddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18		DURHAM	XXX-XX-2763	,						×	X	×	X	X	X	X	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

FLOR D FABELA ESTRADA 32 Jared Way Chatsworth, GA 30705-3301

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	oloyee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	I security number	r (SSN)	7 Name of em	ployer			8 Em	ployer identifica	ation number (EIN)		
FLOR		D FABE	LA ESTRADA	١	XXX-XX-25	524	Campbell F	Printing Com	pany, Inc.			581366	5997		
3 Street address (in	ncluding apartr	ment no.)		•			9 Street addre	ss (including roor	n or suite no.)		10 Cor	10 Contact telephone number			
32 Jared Way	,						2055 Cleveland Hwy					7062593344			
4 City or town		5 State or provi	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13 Cou	13 Country and ZIP or foreign postal code			
Chatsworth		GA		US 30	705-3301		Dalton		GA US 30721						
Part II Emp	oloyee Off	er of Cove	rage	•	Employee'	s Age on J	anuary 1		Plan Star	t Month (er	ter 2-digit n	-digit number): 0			
Part II Employee Offer of Coverage Employee's Ag All 12 Months Jan Feb Mar Apr							June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2A		
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

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Part I Emp	ployee						Α	pplicable L	arge Emplo	yer Memb	er (Employ	er)			
1 Name of employ	ee (first name,	middle initial, I	ast name)	2 Socia	al security numl	ber (SSN)	7 Name of emp	oloyer			8 Emp	loyer identification	n number (EIN)		
IDELIZ		FEBI	RES ORTIZ		XXX-XX-	0531	Campbell F	Printing Com	npany, Inc.			5813669	97		
3 Street address (i	including aparti	ment no.)		•			9 Street addres	ss (including roo	m or suite no.)		10 Con	tact telephone nu	ımber		
32 Jared Way	1						2055 Cleve	eland Hwy				7062593344			
4 City or town		5 State or pro	vince	6 Count	try and ZIP or for	reign postal code	11 City or town		12 State or pro	ovince	13 Cour	13 Country and ZIP or foreign postal code			
Chatsworth GA US 30705-3 Part II Employee Offer of Coverage Empl					0705-3301	5-3301 Dalton GA					US 3	0721			
Part II Emp	oloyee Off	er of Cove	erage		Employe	e's Age on .	January 1		Plan Star	t Month (en	ter 2-digit nu	digit number): 06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2H	2H	2H		
17 ZIP Code															

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

Cat. No. 60705M

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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

JESSICA A FLORES 32 JARED WAY CHATSWORTH, GA 30705

Form 1095-	J
Department of the Treas	ury

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	loyee							Ap	oplicable L	arge Emplo	yer Memb	er (Employ	er)	
1 Name of employ	ee (first name,	middle initial	I, last name)		2 Social s	ecurity number ((SSN)	7 Name of emp	loyer			8 Emp	loyer identificati	on number (EIN)
JESSICA		A FLORES XXX-XX-2003 Campbell Printing Company, Inc.								581366997				
3 Street address (i	ncluding apart	ment no.)			•			9 Street addres	s (including roor	n or suite no.)		10 Con	tact telephone n	umber
32 JARED WA	λY							2055 Cleve	land Hwy				7062593	344
4 City or town		5 State or p	province		6 Country a	and ZIP or foreigr	postal code	11 City or town		12 State or pro	ovince	13 Cour	itry and ZIP or for	eign postal code
CHATSWOR1	⁻ H	GA			US 307	05		Dalton		GA		US 3	0721	
Part II Emp	loyee Off	er of Cov	verage		E	mployee's	Age on c	January 1		Plan Star	t Month (er	nter 2-digit nu	ımber):	06
	All 12 Months	s Jan	Fel)	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	16	-	1E	1E	1H	1H	1H	1H	1H	1E	1E	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$ 13	5.00 \$	135.00	\$ 135.00	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	21	ł	2H	2H	2A	2D	2D	2D	2D	2H	2H	2A
17 ZIP Code										No. COZOEM				005 € (2004)

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

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Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

James Fowler 5974 Springplace Rd Se Cleveland, TN 37323

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OMB No. 1545-2251

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Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Ser	rvice		Go to www.ir	s.gov/Form1	1095C for inst	tructions an	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	yer Membe	r (Employei	<u>r)</u>			
1 Name of employ	ee (first name, m	iddle initial, last r	name)	2 Social se	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
James		Fowler		X	XX-XX-094	40	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (i	ncluding apartme	ent no.)					9 Street address (including room or suite no.) 10					10 Contact telephone number			
5974 Springpl	ace Rd Se						2055 Clevela	and Hwy				70625933	344		
4 City or town 5 State or province 6 Country and ZIP or foreign postal of						n postal code	11 City or town		12 State or pro	vince	13 Country	and ZIP or fore	eign postal code		
Cleveland	Т	N		US 3732	23		Dalton		GA		US 307	721			
Part II Emp	loyee Offer	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit num	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00\$	135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code		Dadastia	at Nation						No. 60705M				095-C (2024)		

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

Cat. No. 60705M

Form 1095-C (2024)

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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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|Fowler XXX-XX-0940 18 **James** \times \times \times \times \times \times |X| $|\times|$ X $|\times|$ \times 19 Rebecca Fowler XXX-XX-3936 \times \times \times \times \times \times \times |X||X||X||X||X|Fowler Colton XXX-XX-6524 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Leon E Fowler 3895 Dunnagan Rd Rocky Face, GA 30740

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OMB No. 1545-2251

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Internal Revenue Sei	vice		Go to www.ii	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of employer 8					8 Employer identification number (EIN)		
Leon		E Fowler		>	(XX-XX-962	21	Campbell Printing Company, Inc.					581366997		
3 Street address (in	ncluding apartm	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
3895 Dunnaga	an Rd						2055 Clevela	and Hwy				70625933	344	
4 City or town 5 State or province 6 Country and ZIP or foreign posta						postal code	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code	
Rocky Face		GA		US 307	40		Dalton		GA		US 30	721		
Part II Emp	loyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
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Cat. No. 60705M

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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	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) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage																	
	(a) Name of First name, m	covered ir iddle initia	dividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Dakota S Fox 128 Nichols Lane Chatsworth, GA 30705

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OMB No. 1545-2251

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

Internal Revenue Sei	vice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.							
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	8 Employer identification number (EIN)			
Dakota	5	Fox		>	(XX-XX-49)	74	Campbell Pr	inting Comp	oany, Inc.			581366997			
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	10 Conta	ct telephone nu	mber				
128 Nichols La	128 Nichols Lane											7062593344			
4 City or town	5	се	6 Country a	6 Country and ZIP or foreign postal code 11 City or town 12 State or province						13 Countr	y and ZIP or fore	eign postal code			
Chatsworth	US 307	05		Dalton		GA		US 30	721						
Part II Emp	loyee Offer	of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	06		
	All 12 Months	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III Covere			ured coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. \succeq		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May) Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Erendira Vazquez Fraire 200 Hewitt Road Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Erendira		V Fraire		\ \ \ \	(XX-XX-082	25	Campbell Pr	inting Com		581366997					
3 Street address (i	ncluding apartr	ment no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number					
200 Hewitt Ro	oad					2055 Cleveland Hwy						7062593344			
4 City or town		5 State or provin	nce	6 Country a	and ZIP or foreigr	postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign posta			
Dalton		GA		US 307	S 30721 Dalton GA						US 30	721			
Part II Emp	oloyee Off	er of Cover	age	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00)\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0 200		

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

Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Isela Vazquez Fraire 200 Hewitt Drive Dalton, GA 30721

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.								
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)				
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)			
Isela	\	/ Fraire		>	(XX-XX-38)	-XX-3876 Campbell Printing Company, Inc.							581366997			
3 Street address (in	ncluding apartme	ent no.)		•		!	9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber			
200 Hewitt Dri	200 Hewitt Drive											7062593344				
4 City or town 5 State or province				6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign post				
Dalton_ GA				US 307	21	[1	Dalton		GA		US 30	721				
Part II Emp	loyee Offer	of Covera	ige	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	06			
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	§ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code													205.0			

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Juan J Fraire 101 Pamala St Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

vice		Go to www.ii	rs.gov/Form	1095C for insi	tructions and	a tne latest int	ormation.							
loyee						Ар	plicable La	arge Employ	yer Membe	r (Employe	r)			
ee (first name, r	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emple	oyer			8 Emplo	yer identification	on number (EIN)		
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loyee Offe	er of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
Part II Employee Offer of Coverage Employee All 12 Months Jan Feb Mar Apr 14 Offer of Apr Apr							July	Aug	Sept	Oct	Nov	Dec		
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	ee (first name, recluding apartment) bloyee Offe All 12 Months	ployee ee (first name, middle initial, last	bloyee ee (first name, middle initial, last name) J Fraire ncluding apartment no.) It 5 State or province GA bloyee Offer of Coverage All 12 Months Jan Feb 1E 1E \$ 135.00 \$ 135.00 \$	Social s 2 2 2 3 3 3 3	Social security number 2 Social security number 2 Social security number 2 Social security number 3 Social security number 3 Social security number 3 Social security number 3 Social security number 4 Social securit	Social security number (SSN) XXX-XX-4342	Apple Pee (first name, middle initial, last name) 2 Social security number (SSN) 7 Name of employer (STN) 2 Social security number (SSN) 7 Name of employer (STN) 7 Na	Applicable Late (first name, middle initial, last name) Bee (first name, middle initial, last name) J Fraire	Applicable Large Employ Applicable Large Employ Social security number (SSN) 7 Name of employer Campbell Printing Company, Inc. 9 Street address (including room or suite no.) 2055 Cleveland Hwy Social State or province GA	Applicable Large Employer Member See (first name, middle initial, last name) 2	Applicable Large Employer Member (Employer Berployer Berployer Berployer Campbell Printing Company, Inc. 10 Contact Campbell Printing Company, Inc. 10	Applicable Large Employer Member (Employer)		

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

Cat. No. 60705M

Form 1095-C (2024)

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You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

DYLAN A FRANKLIN 481 Scarlet Dr Dalton, GA 30721-7893

Form 1095- C	
Department of the Treasury	
Internal Davisaria Camilea	

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

Internal Revenue Se	rvice		Go to www	irs.gov/Fo.	<i>rm10</i> 95C for in	nstructions a	nd the latest	information.							
Part I Emp	oloyee						1	Applicable I	Large Emp	loyer Memb	oer (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Soci	al security numbe	er (SSN)	7 Name of en	nployer			8 Er	nployer identific	ation number (EIN)		
DYLAN		A FRAN	IKLIN		XXX-XX-1	856	Campbell	Printing Cor	mpany, Inc.			581366997			
3 Street address (i	ncluding apartr	ment no.)		'			9 Street addre	ess (including roo	om or suite no.)		10 Co	10 Contact telephone number			
481 Scarlet D	r						2055 Clev	eland Hwy		7062593344					
4 City or town 5 State or province 6 Country and ZIP or foreign pos							11 City or towr	n	12 State or	province	13 Co	untry and ZIP or	foreign postal code		
Dalton GA US 30721-7893							Dalton		GA		US	30721			
Part II Emp	oloyee Off	er of Cove	rage	!	Employee	's Age on	January 1		Plan Sta	art Month (e	nter 2-digit ı	number):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2A	2A	2A		
17 ZIP Code													1005 0		

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Cat. No. 60705M

Form 1095-C (2024)

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- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Jonathan A Freeman 4506 Bluffwood Way Cohutta, GA 30710

Form	1	U	9	5	-C
Depar					easury

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	rvice		Go to www.i	rs.gov/Form	1095C for ins	tructions and	d the latest info	ormation.							
Part I Emp	oloyee						Apı	plicable La	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Er	mployer identific	ation number (EIN)		
Jonathan	/	A Freema	an	>	XXX-XX-3332 Campbell Printing Company, Inc.							581366	5997		
3 Street address (i	ncluding apartm	ent no.)		'		!	9 Street address	(including roon	n or suite no.)		10 C	ontact telephone	number		
4506 Bluffwoo	od Way]:	2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or provin	се	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Cd	13 Country and ZIP or foreign pos			
Cohutta		GΑ		US 307	10		Dalton		GA		US	30721			
Part II Emp	oloyee Offe	r of Covera	age	E	mployee's	Age on J	anuary 1		Plan Start	t Month (en	ter 2-digit	number):	06		
	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	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2H	2H	2H	2A	2A	2A	2A		
17 ZIP Code													1005 0 (200)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I rt III Covere	ed Indi oyer pro	viduals vided self-insur	ed coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered ir	ndividual(s) II, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Jonathan	A	Freeman	XXX-XX-3332			X	X	×	X	×			Aug	С			Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Norma C Freitez 304 N Tibbs Rd Dalton, GA 30720

Form	10	195	-C
Depar	tment	of the Ti	reasury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	vice		Go to www.i	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Norma		C Freitez		>	XX-XX-028	38	Campbell Pr	inting Com		5813669	97			
3 Street address (in	ncluding apartm	ent no.)		'			9 Street address	(including room	10 Conta	10 Contact telephone number				
304 N Tibbs Rd							2055 Cleveland Hwy					7062593344		
4 City or town	5	State or province	се	6 Country a	ry and ZIP or foreign postal code 11 City or town 12 State or province			vince	13 Country and ZIP or foreign postal code					
Dalton		GA		US 307	20		Dalton		GA		US 30	721		
Part II Emp	loyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													00E C (200	

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

ALICIA MITCHELLE GALLEGOS 112 W Locust St Chatsworth, GA 30705-2512

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Internal	Rovenue Sen	/ica

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	ı.ırs.gov/Fo	rm1095C for in	structions ar	nd the latest ii								
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ıst name)	2 Soci	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identifica	ation number (EIN)		
ALICIA		M GALL	.EGOS		XXX-XX-40	052	Campbell I	Printing Con		581366997					
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
112 W Locust	St					2055 Cleve	eland Hwy		7062593344						
4 City or town		5 State or prov	rince	6 Count	try and ZIP or forei	gn postal code	e 11 City or town 12 State or province 13				13 Co	ountry and ZIP or	foreign postal code		
Chatsworth GA US 30705-2512							Dalton GA U					US 30721			
Part II Emp	oloyee Off	er of Cove	rage	Employee	's Age on c	January 1		Plan Star	rt Month (er	nter 2-digit	digit number): 0				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D		
17 ZIP Code													1005 0 222		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18												Aug	Зері			
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

JONATHAN M GARCIA 646 Floodtown Rd Chatsworth, GA 30705-5028

Form	10	95-	-C
		f the Tre	

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	rvice		Go to www.	irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest ir								
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identifica	tion number (EIN)		
JONATHAN		M GARC	CIA		XXX-XX-19	933	Campbell F	Printing Com		581366	997				
3 Street address (i	ncluding apartn	nent no.)					9 Street addres	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
646 Floodtowi	n Rd					2055 Cleve	eland Hwy		7062593344						
4 City or town	:	5 State or provi	ince	6 Counti	ry and ZIP or forei	gn postal code	e 11 City or town 12 State or province 13 C				13 Co	untry and ZIP or t	oreign postal code		
Chatsworth		GA		US 30	705-5028		Dalton		GA		US :	JS 30721			
Part II Emp	oloyee Offe	er of Cove	rage	Employee'	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit r	git number): 06				
All 12 Months Jan Feb Mar Apr							June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D		
17 ZIP Code									N- 00705M				1005 € (200.4)		

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

Cat. No. 60705M

Instructions for Recipient

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

James M Garrett 5001 Upper River Road Charleston, TN 37310

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	vice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.							
Part I Emp	loyee						Apı	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, mi	iddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of employer					8 Employer identification number (EIN)			
James	№	1 Garrett		\	(XX-XX-20)	76	Campbell Pr	inting Comp	oany, Inc.			581366997			
3 Street address (in	ncluding apartme	ent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
5001 Upper R	iver Road];	2055 Clevela	and Hwy				70625933	44		
4 City or town	5	State or province	се	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Charleston	т	N		US 373	10	[1	Dalton		GA		US 30	721			
Part II Emp	loyee Offer	of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ente	er 2-digit nun	nber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter equired code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see nstructions)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	125.00	S 125.00	\$ 125.00		
6 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													205. 2		

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Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Garrett XXX-XX-2076 18 M **James** 19 20 21 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Danny Godfrey 350 Ceder Springs Rd Se Cleveland, TN 37323

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Employ	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	8 Employer identification number (EIN)		
Danny		Godfrey	/	\ \ \	(XX-XX-812	24	Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartm	ent no.)		•			9 Street address (including room or suite no.) 10					10 Contact telephone number		
350 Ceder Sp	rings Rd Se	9					2055 Clevela	and Hwy				7062593344		
4 City or town 5 State or province 6 Country and ZIP or foreign post						postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
Cleveland	7	ΓΝ		US 373	23		Dalton		GA		US 30	721		
Part II Emp	oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													005 0	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

MICHAEL D GOFORTH 1737 Riverbend Rd Dalton, GA 30721-5977

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

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2024

Internal Revenue Ser	rvice		Go to	www.irs.	irs.gov/Form1095C for instructions and the latest information.											
Part I Emp	oloyee							A	oplicable L	arge Emplo	yer Memb	er (Employ	/er)			
1 Name of employ	ee (first name,	middle initia	l, last name)		2 Social	security number	(SSN)	7 Name of emp	loyer			8 Em	ployer identific	ation number (EIN)		
MICHAEL		D GO	FORTH			XXX-XX-21	94	Campbell Printing Company, Inc.					581366997			
3 Street address (in	ncluding apartr	ment no.)						9 Street address (including room or suite no.)					10 Contact telephone number			
1737 Riverber	nd Rd							2055 Cleve	land Hwy				706259	3344		
4 City or town 5 State or province 6 Country and ZIP or foreign postal cou						n postal code	11 City or town	•	12 State or pro	ovince	13 Cou	intry and ZIP or	foreign postal code			
Dalton		GA			US 307	721-5977		Dalton		GA		US 3	US 30721			
Part II Emp	loyee Offe	er of Co	verage			Employee's	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit n	umber):	06		
	All 12 Months	Jan	Feb		Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A		2A	2A	2A	2A	2A	2D	2A	2A	2A	2A		
17 ZIP Code																

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

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Alba Gomez 211 S Grimes Street Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Service Go to www.irs.gov/Formiosoc for instru								u me iatest im	ormation.							
Part I Em	ployee							Ар	plicable La	arge Employ	er Membe	er (Employe	er)			
1 Name of employ	yee (first name,	middle in	itial, last r	name)	2 Social	security number	(SSN)	7 Name of empl	oyer			8 Emplo	oyer identification	on number (EIN)		
Alba		G	Somez			XXX-XX-53	42	Campbell Pr	inting Com		581366997					
3 Street address (including apart	ment no.)							(including roon	n or suite no.)		10 Conta	10 Contact telephone number			
211 S Grimes	s Street							2055 Clevel	and Hwy				7062593344			
4 City or town		5 State of	or provinc	e	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	ry and ZIP or for	reign postal code		
Dalton GA					US 307	' 21		Dalton		GA		US 30	721			
Part II Em	overa	ge		Employee's	Age on J	anuary 1		Plan Start	Month (ent	ter 2-digit nur	mber):	06				
All 12 Months Jan Feb				Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1	E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 1	35.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00)\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2	!C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code																

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

Cat. No. 60705M

Instructions for Recipient

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Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

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Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- 1Y. Reserved for future use.
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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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Alba XXX-XX-5342 18 Gomez 19 20 21 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Mirna B Gomez 315 S Grade Drive Dalton, GA 30721

Form	10	95	-C
Depar	tment	of the T	reasury

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Service Go to www.irs.gov/Formiosoc for instruction								u the latest lill	ormation.									
Part I Emp	oloyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	er)					
1 Name of employ	ee (first name,	middl	e initial, last n	ame)	2 Social s	security number (SSN)	7 Name of emplo	oyer			8 Empl	oyer identificatio	n number (EIN)				
Mirna		В	Gomez			XXX-XX-7327			inting Com		581366997							
3 Street address (i	including aparti	ment r	no.)						(including room	or suite no.)		10 Cont	10 Contact telephone number					
315 S Grade	Drive							2055 Clevela	and Hwy				7062593344					
4 City or town		5 Sta	te or province	Э	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Coun	13 Country and ZIP or foreign postal code					
Dalton GA						'21		Dalton		GA		US 30)721					
Part II Employee Offer of Coverage						Employee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit number): 06						
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)	\$	\$	135.00\$	S 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C				
17 ZIP Code																		

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

Cat. No. 60705M

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Pa		loyer pro	vided self-insu	red coverage, check th			on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of First name, r	f covered ir niddle initia	ndividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Mirna	В	Gomez	XXX-XX-7327			\times	\boxtimes	\times	\times	\times	\times	X	\times	\times	\times	X	\times
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Page 4

Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Alejandro Gomez Arteaga 1425 Kammi St Dalton, GA 30720

Form	I 09:	5-C
Departi	ment of the	Treasury
Intorna	I Dovonuo 9	Condoo .

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	vice		GO TO WWW	.irs.gov/Forn	n 1095C for in	structions ai	ia the latest in	itormation.					
Part I Emp	loyee						A	pplicable L	arge Emplo	yer Memb	er (Emplo	oyer)	
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	ition number (EIN)
Alejandro		Gome	z Arteaga		XXX-XX-2981			Printing Com		581366997			
3 Street address (i	ncluding apartme	ent no.)		<u> </u>			9 Street addres	ss (including roo	m or suite no.)		10 C	Contact telephone	number
1425 Kammi \$	St						2055 Cleve	land Hwy				706259	3344
4 City or town	5	State or provi	nce	6 Country	and ZIP or foreig	gn postal code	11 City or town		12 State or pro	ovince	13 C	ountry and ZIP or	oreign postal code
Dalton	US 30	720		Dalton		GA		US	US 30721				
Part II Emp	loyee Offer	r of Cover	age		Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit	number):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2A	2A	2A	2A	2A	2A	2A
17 ZIP Code													1005.0

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Cat. No. 60705M

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Yanet Gomez Arteaga 1425 Kammi St Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	vice		GO to www	ırs.gov/Fori	m 1095C for in	structions ar	ia the latest ii	ntormation.							
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)			
1 Name of employe	ee (first name, n	niddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Yanet		Gome	z Arteaga		XXX-XX-13	331	Campbell Printing Company, Inc.					58136	5997		
3 Street address (in	ncluding apartm	ent no.)		'			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
1425 Kammi S	St						2055 Cleve	eland Hwy				7062593344			
4 City or town	5	State or provi	ince	6 Countr	6 Country and ZIP or foreign postal code		11 City or town		12 State or p	province	13 Co	13 Country and ZIP or foreign postal code			
Dalton		GA		US 30	US 30720				GA		US :	30721			
Part II Emp	rage	Employee'	s Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit r	iumber):	06					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code													1005.0		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

EMMA GONZALEZ 140 Springfield Dr Chatsworth, GA 30705-8292

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	vice		GO TO WWI	v.irs.gov/Fori	m 1095C for in	structions a	na tne latest ir	ntormation.					
Part I Emp	loyee						Α	pplicable L	arge Emplo	yer Memb	er (Emp	loyer)	
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identifica	tion number (EIN)
EMMA	1	GONZ	ALEZ		XXX-XX-45	564	Campbell F	Printing Con	npany, Inc.			581366	997
3 Street address (in	ncluding apartm	ent no.)					9 Street addres	ss (including roo	m or suite no.)		10	Contact telephone	number
140 Springfiel	d Dr						2055 Cleve	eland Hwy				706259	3344
4 City or town		State or provi	nce	6 Country	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13	Country and ZIP or t	oreign postal code
Chatsworth		GΑ		US 30	705-8292		Dalton		GA		U:	S 30721	
Part II Emp	loyee Offe	r of Cover	age	•	Employee'	s Age on	January 1		Plan Star	t Month (e	nter 2-digi	it number):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2A	2A	2A
17 ZIP Code				oo sonarato ii					No. 60705M				1095-0 (2024)

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

Cat. No. 60705M

Form 1095-C (2024)

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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Michael Gonzalez 536 Reed Rd Apt A Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for instru							a the latest int	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social se	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Michael		Gonzale	ez	×	(XX-XX-138	31	Campbell Printing Company, Inc.					5813669	97		
3 Street address (i	ncluding apartm	ent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
536 Reed Rd	Apt A						2055 Cleveland Hwy					7062593344			
4 City or town	5	State or provinc	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton		GA		US 3072	US 30720				GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I rt III Cove ı If Emp	red Indiv loyer prov	riduals rided self-insure	ed coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, r	f covered ind niddle initial	dividual(s) , last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Michael		Gonzalez	XXX-XX-1381	,		X	X	X	X	×	X	X	X	Х	×	X	X
19	Talia		Gonzalez	XXX-XX-8309			X	\times	X	\times	X	X	X	\times	\times	\times	\times	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Rosalba Gonzalez De Ponce 1726 Walton Street Dalton, GA 30721

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Depar						
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Ser	vice		GO to www.iis	s.gov/roiiii	1095C IOI IIIS	u ucuons and	i tile latest lille	ormation.			1		
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	er)	
1 Name of employe	ee (first name, r	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emple	oyer identification	n number (EIN)
Rosalba		Gonzal	ez De Ponce	>	(XX-XX-099	90 (Campbell Pr	inting Com	pany, Inc.			5813669	97
3 Street address (in	ncluding apartm	nent no.)				9	9 Street address	(including room	or suite no.)		10 Conta	act telephone nu	ımber
1726 Walton S	Street					[2	2055 Clevela	and Hwy				70625933	344
4 City or town	5	5 State or provin	се	6 Country a	and ZIP or foreigr	n postal code 1	1 City or town	•	12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code
Dalton	-	GA		US 307	21	1	Dalton		GA		US 30	721	
Part II Emp	loyee Offe	er of Covera	age	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nui	mber):	06
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\{</i>	\$ 125.00	\$ 125.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H
17 ZIP Code			No.						2070714				005 0 (200)

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

Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Christopher Grace 741 Old Landfill Rd Chatsworth, GA 30705

Form 1095	-C
Department of the Tr	easury

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	vice		GO to www.n	is.gov/roilli	rosse for ills	u ucuons and	a tile latest lilli	ormation.					
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)	
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)
Christopher		Grace		×	(XX-XX-387	79	Campbell Pr	inting Com	pany, Inc.			5813669	97
3 Street address (in	ncluding apartr	nent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber
741 Old Landf	ill Rd						2055 Clevela	and Hwy				70625933	344
4 City or town	,	5 State or province	ce	6 Country a	nd ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code
Chatsworth		GA		US 3070	05		Dalton		GA		US 30	721	
Part II Emp	loyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code													005 0 (200)

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Cat. No. 60705M

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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere If Employ	d Individuals yer provided self-in:	sured coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of co	overed individual(s) ddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Christopher	Grace	XXX-XX-3879			X	X	X	X	X	X	X	X	Ж	×	X	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Albert Griffin 688 Lake Katherine Rd Tunnel Hill, GA 30755

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Form	IU	JJ	U
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	rvice		GO to www.n	s.gov/Form	1093C IOI IIIS	u ucuons and	u tile latest lilli	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, i	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Albert		Griffin		X	(XX-XX-953	37	Campbell Printing Company, Inc.					581366997		
3 Street address (in	ncluding apartn	nent no.)		•		!	9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber	
688 Lake Kath	nerine Rd]:	2055 Clevela	and Hwy				70625933	344	
4 City or town	,	5 State or province	се	6 Country a	and ZIP or foreigr	postal code 1	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code	
Tunnel Hill		GA		US 307!	55		Dalton		GA		US 30	721		
Part II Emp	loyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00 <i>\$</i>	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													005 0 (200)	

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Albert Griffin XXX-XX-9537 18 19 20 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

WILLIAM HARRISON 1116 WILLOWDALE RD NW, APT 214 DALTON, GA 30720

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Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for instruction						structions ar	is and the latest information.								
Part I Emp	oloyee						A	oplicable L	er (Employ	er)					
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Social	security number	(SSN)	7 Name of emp	loyer			8 Em	ployer identifica	tion number (EIN)		
WILLIAM		HARR	ISON		XXX-XX-16	47	Campbell F	rinting Com		581366997					
3 Street address (including apartment no.)							9 Street addres	s (including roo	m or suite no.)		10 Cor	10 Contact telephone number			
1116 WILLOWDALE RD NW APT 214							2055 Cleve	land Hwy				7062593	3344		
4 City or town 5 State or province 6 Country and ZIP or foreign postal co							11 City or town		12 State or pro	ovince	13 Cou	ntry and ZIP or fo	oreign postal code		
DALTON		GA		US 30	720		Dalton		GA		US 3	0721			
Part II Emp	oloyee Off	er of Cover	age		Employee's	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit n	umber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D		
17 ZIP Code															

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Joseph S Headrick 2715 Brooks Drive Rocky Face, GA 30740

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Intern	al Roya	anua 9	Sarvio	٠.

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	rvice			GO to www.n	s.gov/Form	10930 101 1115	u ucuons am	u tile latest lill	ormation.							
Part I Emp	loyee							Ар	plicable La	r (Employe	r)					
1 Name of employ	ee (first name, i	middle initi	ial, last na	ame)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Joseph		S He	adrick	(>	(XX-XX-684	41	Campbell Pr	inting Com		5813669	97				
3 Street address (including apartment no.)								9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
2715 Brooks Drive								2055 Clevela	and Hwy				7062593344			
4 City or town	:	5 State or	province)	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code		
Rocky Face		GA			US 307	40		Dalton		GA		US 30	721			
Part II Emp	loyee Offe	er of Co	overaç	je	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	All 12 Months	Ja	n	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)	\$	\$ 13	5.00 \$	3 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		20		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code														005 0 (200)		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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Pa	I rt III Covere			ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Joseph	S	Headrick	XXX-XX-6841	,		X	×	X	X	×	×		X	Ж	×	X	X
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Part III. Covered Individuals, Lines 18–30

David F Higgins Jr 1132 Smyrna Chuch Rd Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

ormation

2024

Internal Revenue Ser	vice		Go to www.ir	s.gov/Form	1095C for ins											
Part I Emp	loyee						Ар	plicable La	r (Employe	r)						
1 Name of employe	ee (first name, m	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)			
David	F	Higgins	S	>	XXX-XX-318	33	Campbell Pr	inting Com		5813669	97					
3 Street address (in	ncluding apartme	ent no.)				!	9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
1132 Smyrna	Chuch Rd];	2055 Cleveland Hwy					7062593344				
4 City or town	5	State or province	се	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Counti	13 Country and ZIP or foreign postal code				
Chatsworth	G	ŝΑ		US 307	05	[1	Dalton		GA		US 30	721				
Part II Emp	loyee Offer	of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	r 2-digit number): 06				
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code			A A Notice of										005 0 (200)			

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

Cat. No. 60705M

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jackie D Higgins 1104 Walston St, Apt B 208 Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Se	rvice		GO to www.ii	s.gov/Formi	1095C IOI IIISI	ructions and	u the latest illi	ormation.			I				
Part I Emp	oloyee						Ap	plicable La	rge Employ	yer Membe	r (Employe	r)			
1 Name of employ	vee (first name, i	middle initial, last	name)	2 Social se	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Jackie		D Higgins		X	XX-XX-445	53	Campbell Pr	inting Com		581366997					
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
1104 Walston	St Apt B 2	08					2055 Clevela	and Hwy				70625933	344		
4 City or town		5 State or province	ce	6 Country a	nd ZIP or foreign	postal code	11 City or town	•	12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code		
Dalton		GA		US 3072	20		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
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Cat. No. 60705M

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- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	irt III C	overe Employ	d Indi er pro	viduals vided self-insu	red coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Na First na	ame of co	vered ir dle initia	idividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Joe W Higgins 1132 Smyrna Church Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	rvice		GO LO WWW.I	is.gov/Form	10930 101 1115	u ucuons and	a tile latest lilli	ormation.					
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)	
1 Name of employ	ee (first name, i	middle initial, las	t name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)
Joe		W Higgins	S	>	(XX-XX-282	29	Campbell Pr	inting Com		581366997			
3 Street address (in		9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number						
1132 Smyrna		2055 Clevela	and Hwy				7062593344						
4 City or town									12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code
Chatsworth		Dalton		GA		US 30	721						
Part II Emp	loyee Offe	er of Cover	age	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06
	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)	\$	\$ 135.00	\$ 135.00\$	S 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code													005 0 (200)

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	irt III C	overed Ind Employer pro	ividuals ovided self-ins	ured coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					mploye	ee. 🗵		
	(a) Na First na	ame of covered i ame, middle initi	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18		W	Higgins	XXX-XX-2829	,		X	×	X	X	×	X	×	X	X	X	X	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Tina M Higgins 1116 Willowdale Rd NW, Ste 215 Dalton, GA 30720

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Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for instruct							a tne latest int	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	er (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)		
Tina		M Higgins	;	\ \ \	(XX-XX-905	54	Campbell Pr	inting Com		581366997					
3 Street address (in	ncluding apartm	nent no.)		•			9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
1116 Willowda	ale Rd NW	Ste 215					2055 Clevel	and Hwy				70625933	344		
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Countr	ry and ZIP or fore	eign postal code		
Dalton GA US 30720							Dalton		GA		US 30	721			
Part II Employee Offer of Coverage US 30720 Employee's Ag							anuary 1		Plan Start	Month (ent	er 2-digit nur	mber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Kenneth L Holland 643 Champagne Trail Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	oloyee							App	olicable La	rge Emplo	yer Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle	e initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	yer			8 Emp	8 Employer identification number (EIN)		
Kenneth		L	Holland			XXX-XX-97	14	Campbell Pri	inting Com	pany, Inc.			581366997		
3 Street address (i	including apartr	nent n	10.)					9 Street address	(including room	10 Cont	10 Contact telephone number				
643 Champag	gne Trail							2055 Clevela	nd Hwy				7062593344		
4 City or town		5 Sta	te or provinc	се	6 Country	and ZIP or foreigi	n postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code		
Dalton		GΑ			US 307	'21		Dalton GA				US 30	US 30721		
Part II Emp	oloyee Off	er of	f Covera	ge		Employee's	Age on J	anuary 1		Plan Start	Month (ente	er 2-digit nu	ımber):	06	
	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)	\$	\$	135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code															

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|18 Holland XXX-XX-9714 Kenneth \times \times \times \times \times \times |X| $|\times|$ X $|\times|$ \times 19 Holland XXX-XX-5435 Tonya \times \times \times \times \times \times \times |X||X||X||X||X|Summer Ν Holland XXX-XX-7628 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Gage Howard 101 Timbervale Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of employer				8 Emplo	8 Employer identification number (EIN)			
Gage		Howard	l	X	(XX-XX-017	70	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (i	ncluding apartr	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
101 Timberva	le Drive						2055 Clevela	and Hwy				70625933	344		
4 City or town 5 State or province 6 Country and ZIP or foreign postal						postal code	11 City or town		12 State or pro	vince	13 Countr	ry and ZIP or fore	eign postal code		
Dalton		GA		US 3072	21		Dalton GA				US 30	US 30721			
Part II Emp	loyee Off	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0 200		

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

Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

GRACIE HOWARD 126 CRABTREE DR TUNNEL HILL, GA 30755

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	vice		Go to www	.irs.gov/Forn	<i>n10</i> 95C for in	structions ar	nd the latest ir	nformation.							
Part I Emp	loyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employe	ee (first name, m	niddle initial, last	t name)	2 Social	security numbe	r (SSN)	7 Name of emp	ployer			8 Er	nployer identifica	tion number (EIN)		
GRACIE		HOWA	.RD		XXX-XX-18	399	Campbell F	Printing Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartme	ent no.)		'			9 Street address (including room or suite no.) 10					ontact telephone	number		
126 CRABTRI	EE DR						2055 Cleve	eland Hwy				706259	3344		
4 City or town	5	State or provin	nce	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13 Cd	ountry and ZIP or	oreign postal code		
TUNNEL HILL	. (GΑ		US 307	755		Dalton GA L				US	US 30721			
Part II Emp	loyee Offe	r of Covera	age	·	Employee'	's Age on .	January 1		Plan Star	t Month (e	nter 2-digit	number):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code									No. 00705M				1005 C (0004)		

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

Cat. No. 60705M

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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Michael E Howard 101 Timbervale Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Ap	plicable La	arge Employ	yer Membe	er (Employe	er)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social se	ecurity number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identificatio	n number (EIN)	
Michael		E Howard	ł	X	(XX-XX-77)	30 (Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartm	ent no.)				!	9 Street address	(including room	10 Cont	10 Contact telephone number				
101 Timberva	le Drive						2055 Clevela	and Hwy		7062593344				
4 City or town	5	State or province	ce	6 Country a	nd ZIP or foreigr	n postal code 1	1 City or town		12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code	
Dalton GA				US 3072	21	1	Dalton		GA		US 30	721		
Part II Employee Offer of Coverage				E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	ter 2-digit nu	mber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code														

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I rt III Co v If Er	vered In mployer p	div rov	riduals rided self-insur	ed coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Nam First nam	ne of covered ne, middle in	d ind	dividual(s) last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Johnny E Ison 264 Loudermilk Rd Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Sei	vice		GO LO WWW.II	s.gov/Formi	1095C IOI IIISI	ructions and	a tile latest lille	ormation.				~_			
Part I Emp	loyee						Ap	plicable La	rge Employ	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, r	niddle initial, last i	name)	2 Social se	ecurity number (SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Johnny		E Ison		X	XX-XX-998	33	Campbell Printing Company, Inc.					581366997			
3 Street address (in	ncluding apartm	nent no.)					9 Street address (including room or suite no.) 10 C					10 Contact telephone number			
264 Loudermi	lk Rd]:	2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or provinc	е	6 Country a	nd ZIP or foreign	postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Chatsworth GA				US 3070	Dalton GA				US 30	721					
Part II Employee Offer of Coverage Em					mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00 \$	135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	S 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code									I- COZOSM				005 € (2004)		

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

Cat. No. 60705M

Instructions for Recipient

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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Israel D Jimenez 404 Oakland Trail Se Cleveland, TN 37323

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

2024

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Israel D Jimenez XXX-XX-4697 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 404 Oakland Trail Se 2055 Cleveland Hwv 7062593344 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 Cleveland ΤN US 37323 Dalton GA US 30721 **Employee Offer of Coverage** Employee's Age on January 1 Plan Start Month (enter 2-digit number): Part II 06 All 12 Months Feb Oct Dec Jan Mar Apr May June July Sept Nov 14 Offer of Coverage (enter 1E required code) 15 Employee Required Contribution (see 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 125.00\$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 \$ 125.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2H 2H 2H 2H 2H 2H 2H code, if applicable) 2H 2H 2H 2H 2H 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

William H Kregel 1211 Peabody Drive Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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

VOID

Internal Revenue Ser	vice		Go to www.ir	s.gov/Form	1095C for ins	tructions and	d the latest info	ormation.								
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)				
1 Name of employ	ee (first name, mi	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)			
William		l Kregel		>	XXX-XX-559	95	Campbell Pr	inting Com		5813669	97					
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
1211 Peabody	/ Drive				2055 Cleveland Hwy							7062593344				
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code			
Dalton	G	ŝΑ		US 30720			Dalton		GA		US 30	721				
Part II Emp	loyee Offer	of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	Month (ente	er 2-digit nur	nber):	06			
All 12 Months Jan Feb Mar						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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C			
17 ZIP Code			Lat Nation and										005 0 (200)			

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Cove	red Indi loyer pro	viduals ovided self-ins	ured coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name,	of covered in	ndividual(s) al. last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	William	Н	Kregel	XXX-XX-5595			X	X	×	X	×	X	X	X	Ж	X	X	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Kenneth Laster 295 Cobb Rd Chatsworth, GA 30705

Form	10	195	-C
Depar	tment	of the Tr	easury

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

OMB No. 1545-2251

VOID

					.irs.gov/Forn	n 1095C for ins	structions and	ns and the latest information.								
Part I Emp	oloyee							Apı	plicable La	r (Employe	er)					
1 Name of employ	ee (first name,	middle	e initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emp	loyer identification	on number (EIN)		
Kenneth			Laster			XXX-XX-96	02	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	including apartı	ment n	10.)					9 Street address	(including room	10 Cont	10 Contact telephone number					
295 Cobb Rd								2055 Clevela	and Hwy				7062593344			
4 City or town		5 Sta	te or provinc	ce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Coun	try and ZIP or for	eign postal code		
Chatsworth		GA			US 30	705		Dalton		GA		US 30	US 30721			
Part II Emp	Part II Employee Offer of Coverage						s Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nu	-digit number):			
	All 12 Months Jan Feb					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)	\$	\$	135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code																

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Cat. No. 60705M

Form 1095-C (2024)

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Carol A Macon 931 Ohare Dr Dandridge, TN 37725

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Depar	tme	ent d	of th	ne T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for inst							a the latest int	ormation.							
Part I Emp	loyee						Ар	plicable La	r (Employe	r)					
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Carol		A Macon)	(XX-XX-818	39	Campbell Pr	inting Com		5813669	97				
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
931 Ohare Dr			2055 Clevela	and Hwy				7062593344							
4 City or town 5 State or province 6 Country and 2						postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dandridge	TN	US 377	25		Dalton		GA		US 30	US 30721					
Part II Employee Offer of Coverage Em						Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

JOSEFINA MARTINEZ 206 FOSTER RD DALTON, GA 30720

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	vice		Go to www.	irs.gov/For	<i>m10</i> 95C for in	structions ar	d the latest in	nformation.						
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	ver)		
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)	
JOSEFINA		MART	INEZ		XXX-XX-0	466	Campbell F	Printing Com	npany, Inc.			581366997		
3 Street address (in	ncluding apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Cor	ntact telephone	number	
206 FOSTER			2055 Cleve	eland Hwy				706259	3344					
4 City or town	gn postal code	11 City or town		12 State or p	rovince	13 Cou	ntry and ZIP or	foreign postal code						
DALTON			Dalton		GA		US 3	30721						
Part II Emp	age	's Age on c	January 1		Plan Star	rt Month (er	nter 2-digit n	umber):	06					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2A	2A	2A	2A	
17 ZIP Code			Act Notice and						N- 00705M				1005 C (000 t)	

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

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

ISIDRO MARTINEZ QUINTERO 313 Westwood Cir Dalton, GA 30721-8357

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	.irs.gov/Foi	<i>m10</i> 95C for in	structions an	id the latest ii	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Employ	yer)			
1 Name of employ	vee (first name, r	niddle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identification	on number (EIN)		
ISIDRO		MAR	TINEZ QUINT	ER	XXX-XX-4	379	Campbell F	Printing Con		5813669	97				
3 Street address (i	including apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
313 Westwoo	d Cir						2055 Cleve	eland Hwy				7062593344			
4 City or town	5	State or prov	rince	6 Count	ry and ZIP or forei	gn postal code	11 City or town 12 State or			ovince	13 Cou	untry and ZIP or for	eign postal code		
Dalton		GA		US 30	0721-8357		Dalton		GA		US 3	30721			
Part II Emp	oloyee Offe	r of Cove	rage		Employee	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit n	umber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2H	2H		
17 ZIP Code													005 0 (222)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Patrick A Mealer 3509 Hurricane Rd Rocky Face, GA 30740

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Ser	vice		GO LO WWW.II	s.gov/Form	1093C IOI IIIS	u ucuons and	i tile latest lille	ormation.							
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, r	middle initial, last	name)	2 Social s	security number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Patrick		A Mealer			XXX-XX-667	79 (Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartm	nent no.)				9	9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
3509 Hurrican	e Rd				2055 Cleveland Hwy							7062593344			
4 City or town		5 State or provin	се	6 Country and ZIP or foreign postal code			1 City or town	•	12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal			
Rocky Face		GA		US 307	40	[Dalton		GA		US 30	721			
Part II Emp	loyee Offe	er of Covera	age	E	Employee's	Age on Ja	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													00F C (200)		

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

Cat. No. 60705M

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere			red coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. \succeq		
	(a) Name of First name, m			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18		A	Mealer	XXX-XX-6679	,		X	×	X	X	×	×	X	X	Х	X	×	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

YANIRA MEJIA 1306 Stevenson Dr Dalton, GA 30721-4734

Form	1	O	9	5	-	C
Depar	tme	nt d	of th	ne T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	vice		GO to www.	.irs.gov/For	m 1095C for in	structions ar	ia the latest ii	ntormation.					· — -		
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	per (Employ	/er)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
YANIRA		MEJIA	4		XXX-XX-3	993	Campbell I	Printing Con	npany, Inc.			581366997			
3 Street address (in	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	9 Street address (including room or suite no.)					number		
1306 Stevens	on Dr						2055 Cleve	eland Hwy				706259	3344		
4 City or town	5	State or prov	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Cou	intry and ZIP or	foreign postal code		
Dalton		GA		US 30	721-4734		Dalton GA				US 3	US 30721			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2H		
17 ZIP Code													1005.0		

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Cat. No. 60705M

Form 1095-C (2024)

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- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

FLORIBEYA I MONDRAGON 5149 HWY 225 N CHATSWORTH, GA 30705

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17 ZIP Code

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) **FLORIBEYA** MONDRAGON XXX-XX-4196 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 5149 HWY 225 N 2055 Cleveland Hwv 7062593344 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 **CHATSWORTH** GA US 30705 Dalton GA US 30721 Part II Employee Offer of Coverage **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 06 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H 1H 1H 1H 1H 1H 1H 1H 1H 1E 1H 1H required code) 15 Employee Required Contribution (see 125.00 \$ instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2D 2A 2A 2A 2A 2A 2A 2D 2A code, if applicable) 2A 2H

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Anthony Montgomery 784 Mcghee PI Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN) 7	Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Anthony		Montgo	mery	>	XX-XX-08	11 (Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartm	ent no.)				9	Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber		
784 Mcghee F	기					2	2055 Clevela	and Hwy				70625933	344		
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	postal code 1	1 City or town	•	12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code		
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Part II Emp	loyee Offe	r of Covera	ige	E	mployee's	Age on Ja	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code			lat Nation and						2070714				005 (2.00.0)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- 1Z. Reserved for future use.

Pa	Irt III Covere	ed Individuals oyer provided self-insure	ed coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered individual(s) ddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

ISABEL MONTIEL 64 Falcon Cir Chatsworth, GA 30705-3172

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sel	rvice		GO LO WWW.	.irs.gov/rori	11110950 101 111	Structions an	iu trie latest ii	normation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Employ	er)			
1 Name of employ	ree (first name, n	niddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Emp	oloyer identification	on number (EIN)		
ISABEL		MONT	TIEL		XXX-XX-90	015	Campbell Printing Company, Inc.					5813669	97		
3 Street address (including apartment no.)							9 Street addre	ss (including roo	m or suite no.)		10 Con	10 Contact telephone number			
64 Falcon Cir							2055 Cleveland Hwv					7062593344			
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13 Cou	13 Country and ZIP or foreign postal code			
Chatsworth	705-3172		Dalton		GA		US 3	0721							
Part II Emp	oloyee Offe	r of Cover	rage	•	Employee ³	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit nu	-digit number): 06			
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14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2H	2H		
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

SAMUEL MOORE 4601 BLUFFWOOD WAY COHUTTA, GA 30710

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Depar						,

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		GO to www	.irs.gov/Forn	n1095C for in	structions an	ia the latest into	ormation.								
Part I Em	ployee						Ар	plicable La	r (Employe	er)						
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Social	security numbe	r (SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	n number (EIN)			
SAMUEL		MOOF	RE		XXX-XX-67	779	Campbell Pr	inting Com	pany, Inc.			5813669	97			
3 Street address (including apartr	ment no.)					9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number				
4601 BLUFF\	NOOD WA	·Υ					2055 Clevela	and Hwy				7062593344				
4 City or town		5 State or provi	nce	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or pro	vince	13 Count	try and ZIP or for	eign postal code			
COHUTTA		GA		US 30	710		Dalton		GA		US 30	721				
Part II Em	ployee Off	er of Cover	age		Employee'	s Age on J	lanuary 1		Plan Start	Month (ent	er 2-digit nu	-digit number): 06				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 135.00	0 \$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A 2D 2D 2D 2H 2C		2C	2C	2C	2C	2C	2C	2C					
17 ZIP Code																

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

Cat. No. 60705M

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Pa	art III Cover	ed Ind	ividuals ovided self-insur	red coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		-
	(a) Name of	covered i	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other	(d) Covered						Months			I -	_		_
	First name, n	nidale initi	ai, iast name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

BRANDON MORALES 126 LOMA LN DALTON, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest ii	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Emplo	yer identificatio	n number (EIN)		
BRANDON		MORA	ALES		XXX-XX-4	477	Campbell Printing Company, Inc.					5813669	97		
3 Street address (including apartment no.)							9 Street addre	ss (including roo	m or suite no.)		10 Conta	10 Contact telephone number			
126 LOMA LN	J						2055 Cleve	eland Hwy				7062593344			
4 City or town	5	State or provi	ince	6 Counti	6 Country and ZIP or foreign postal code				12 State or p	province	13 Countr	13 Country and ZIP or foreign postal code			
DALTON		GΑ		US 30	720		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Cove	rage		Employee ³	's Age on J	lanuary 1		Plan Sta	rt Month (er	nter 2-digit nun	nber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	§ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2H	2H	2H		
17 ZIP Code													005 0		

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Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

LUIS A MORALES SANTIAGO 163 OAKWOOD CIR CHATSWORTH, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www.	ırs.gov/Foi	<i>m10</i> 95C for in	structions a	nd the latest ii	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name,	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identifica	ation number (EIN)	
LUIS		A MORA	LES SANTIA	AG(XXX-XX-28	311	Campbell I	Printing Com	npany, Inc.			581366997		
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Cd	ontact telephone	number	
163 OAKWO	OD CIR						2055 Cleve	eland Hwy				706259	3344	
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code	
CHATSWOR ⁷	TH	GA		US 30)705		Dalton		GA		US	30721		
Part II Emp	oloyee Off	er of Cover	age	·	Employee ³	's Age on	January 1		Plan Star	rt Month (er	nter 2-digit ı	number):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	
17 ZIP Code													1005 0 000	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Thomas Morrell 49 River Walk Parkway Euharlee, GA 30145

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	vice		GO to www.irs	s.gov/roiiii	10930 101 11151	ructions and	i tile latest lille	ormation.			I		_	
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	ecurity number (SSN)	Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)	
Thomas		Morrell		\ \ \ \	(XX-XX-130	00 (Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartme	ent no.)		_		9	Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber	
49 River Walk	Parkway					2	2055 Clevela	and Hwy				70625933	344	
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign	postal code 1	1 City or town	-	12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code	
Euharlee		ŝΑ		US 301	45]	Dalton		GA		US 30	721		
Part II Emp	loyee Offe	r <mark>of Cover</mark> a	ige	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code									I- 00705M				005 € (200.4)	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

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Part II. Employer Offer of Coverage, Lines 14-17

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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|18 **Thomas** Morrell XXX-XX-1300 \times \times \times \times \times |X| \times X $|\times|$ \times \times 19 XXX-XX-2255 Tracy Morrell \times \times \times \times \times \times \times |X||X||X||X||X|Garrett Morrell XXX-XX-0827 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Amanda Morrison 1330 Coogler Rd Dalton, GA 30721

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Α	pplicable La	arge Emplo	yer Memb	er (Em	ployer)		
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8	B Employer ide	entificat	tion number (EIN)
Amanda		Morriso	n		XXX-XX-08	369	Campbell Printing Company, Inc.					581366997		
3 Street address (including apartment no.)							9 Street addres	ss (including roor	n or suite no.)		10	0 Contact tele	phone i	number
1330 Coogler	Rd						2055 Cleve	eland Hwy				706	52593	3344
4 City or town		5 State or provin	ce	6 Country	and ZIP or foreig	gn postal code	11 City or town		12 State or pro	ovince	13	3 Country and	ZIP or fo	oreign postal code
Dalton		GA		US 30	721		Dalton		GA		lι	JS 30721		
Part II Emp	loyee Off	er of Covera	age	•	Employee'	s Age on .	January 1		Plan Star	t Month (er	nter 2-dig	git number)	:	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	t N	lov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1⊦	1 1	Н	1H
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$)	\$	\$	\$	\$	\$	\$	\$	\$		\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2A	2A	2A	2A	2A	2A	2A	2A	20) 2	2D	2D
17 ZIP Code														1005 0

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

Cat. No. 60705M

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

JUAN C MUNOS 318 W PEACHTREE ST CHATSWORTH, GA 30705

Form 1095-U	į
Department of the Treasu	

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		GO TO WWW	.irs.gov/Forn	n 1095C for in	structions ar	na the latest in	itormation.								
Part I Emp	loyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	oyer)				
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	tion number (EIN)			
JUAN	(MUNC)S		XXX-XX-67	791	Campbell F	Printing Com	pany, Inc.			581366997				
3 Street address (i	ncluding apartme	ent no.)		<u>'</u>			9 Street addres	ss (including roo	10 C	10 Contact telephone number						
318 W PEACH	HTREE ST						2055 Cleve	land Hwy		706259	3344					
4 City or town	5	State or provin	nce	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13 C	13 Country and ZIP or foreign postal code				
CHATSWOR1	гн с	ŝΑ		US 30	705		Dalton		GA		US	US 30721				
Part II Emp	loyee Offe	r of Cover	age		Employee'	s Age on c	January 1		Plan Star	t Month (e	nter 2-digit	number):	06			
	All 12 Months	Feb	Mar	Apr	May	June July		Aug			Nov	Dec				
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2A			
17 ZIP Code													1005.0			

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

Cat. No. 60705M

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Clinton Nichols 33 Furrow Lane Chatsworth, GA 30705

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Form	UJJ-	U
Departme	ent of the Tre	asury
Internal F	Revenue Serv	ice .

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	rvice		GO to www.ii	rs.gov/Form	10930 101 1115	u ucuons and	a tile latest lilli	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Clinton		Nichols	S	\ \ \ \	(XX-XX-752	21	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (in	ncluding apartr	ment no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number				
33 Furrow Lar	ne						2055 Clevela	and Hwy				70625933	344	
4 City or town		5 State or province	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal		
Chatsworth		GA		US 3070	05		Dalton		GA		US 30	US 30721		
Part II Emp	oloyee Off	er of Covera	age	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													005 0 (200)	

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Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Rickey L Nixon PO Box 1061 Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	ue Service Go to www.irs.gov/Form1095C for instructions and the latest information.														
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Rickey		L Nixon) ×	(XX-XX-474	18	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartm	ent no.)		'			9 Street address	(including room	10 Conta	10 Contact telephone number					
PO Box 1061							2055 Clevela	and Hwy		7062593344					
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign post			
Chatsworth		GΑ		US 3070	05		Dalton		GA		US 30	721			
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	-digit number): 0			
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code									I- 00705M				005 € (2004)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III	Covered f Employ	d Indi /er pro	viduals vided self-insu	ured coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					mploye	ee. 🗵		
	(a) First	Name of co	overed ir Idle initia	ndividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Rickey		L	Nixon	XXX-XX-4748	,		X	X	X	X	×	X	×	X	X	X	×	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Tyler H Nixon 482 Glenn Howard Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	rvice		GO to www.n	s.gov/Form	rosse for illis	u ucuons and	u tile latest lilli	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Tyler		H Nixon		X	(XX-XX-38 ⁴	46	Campbell Pr	inting Com	pany, Inc.			581366997		
3 Street address (including apartment no.) 9 Street address (including room or suite no.)							10 Conta	ct telephone nu	ımber					
482 Glenn Ho	ward Road];	2055 Clevela	and Hwy				70625933	344	
4 City or town		5 State or province	ce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code	
Chatsworth		GA		US 3070	05	[1	Dalton		GA		US 30	721		
Part II Emp	loyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00 <i>\</i>	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													005 0 (200)	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times Tyler Nixon XXX-XX-3846 18 Н 19 20 21 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Beatriz Morales Nunez 126 Loma Lane Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		Go to www.i	rs.gov/Form	1095C for inst	tructions and	a tne latest int	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, r	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of employer				8 Emplo	yer identificatio	n number (EIN)	
Beatriz		M Nunez) X	(XX-XX-762	27	Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
126 Loma Lar	ne						2055 Clevel	and Hwy				70625933	344	
4 City or town 5 State or province 6 Country and ZIP or foreign p						n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
Dalton		GA		US 3072	20		Dalton		GA		US 30	721		
Part II Emp	oloyee Offe	er of Covera	nge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06	
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													205.0	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Yarimi Perez Morales 250 3rd Ave E, Apt B Chatsworth, GA 30705

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Depart	ment	of the	Treas	sury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

 $\ensuremath{\text{\textbf{Do}}}$ not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ir	ntormation.						
Part I Emp	oloyee						Α	pplicable La	arge Empl	oyer Memb	er (Emplo	/er)		
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of employer				8 Em	ployer identific	ation number (EIN)	
Yarimi		Perez	Morales		XXX-XX-10	097	Campbell F	Printing Com	pany, Inc.			581366997		
3 Street address (i	ncluding apartm	ent no.)					9 Street addres	ss (including roon	n or suite no.)		10 Co	10 Contact telephone number		
250 3rd Ave E	E Apt B						2055 Cleve	eland Hwy				706259	3344	
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co.	intry and ZIP or	foreign postal code	
Chatsworth		GA		US 30	705		Dalton		GA		US :	30721		
Part II Emp	oloyee Offe	r of Cover	age		Employee ³	s Age on c	lanuary 1		Plan Star	rt Month (e	nter 2-digit n	umber):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1E	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2D	2D	2H	2A	2A	2A	2A	2A	
17 ZIP Code													1005 0	

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

Cat. No. 60705M

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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22																
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

CHRISTOPHER PITTMAN 4177 BROWN BRIDGE RD, Lot EE DALTON, GA 30721

Form	1	U	9	5	_	U
Depar						,

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

20**24**

Internal Revenue Sei	vice		GO to www.ii	s.gov/ron	1110930 101 1118	structions a	ilu tile latest li	normation.					
Part I Emp	loyee						A	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social	security number	(SSN)	7 Name of emp	oloyer			8 En	nployer identifica	ation number (EIN)
CHRISTOPHE	ER	PITTMA	AΝ		XXX-XX-70	14	Campbell F	Printing Com	pany, Inc.			581366	997
3 Street address (in	ncluding apartm	ent no.)					9 Street addres	ss (including roor	n or suite no.)		10 Cd	ntact telephone	number
4177 BROWN	BRIDGE R	RD Lot EE					2055 Cleve	land Hwy				706259	3344
4 City or town	5	State or province	ce	6 Country	y and ZIP or foreig	n postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP or	foreign postal code
DALTON		GA		US 30	721		Dalton		GA		US	30721	
Part II Emp	loyee Offe	r of Covera	ige		Employee's	s Age on	January 1		Plan Star	t Month (en	ter 2-digit r	number):	06
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00 \$		\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A
17 ZIP Code													1005.0

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

Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Jesse A Ramirez 2952 Carol Circle Rocky Face, GA 30740

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Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	vice		G0 10	www.iis.	.gov/roiiii	10930 101 1115	tructions and	a the latest ini	ormation.			1	~-			
Part I Emp	loyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name,	middle initial	last name)		2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Jesse		A Ran	nirez		\	(XX-XX-939	95	Campbell Pr	rinting Com	pany, Inc.			5813669	97		
3 Street address (i	ncluding apartr	nent no.)			•			9 Street address	(including room	or suite no.)		10 Conta	ict telephone nu	ımber		
2952 Carol Ci	rcle							2055 Clevel	and Hwy				70625933	344		
4 City or town		5 State or p	rovince		6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal			
Rocky Face		GA			US 307	US 30740 Dalton GA						US 30	US 30721			
Part II Employee Offer of Coverage Employee's Ag								anuary 1		Plan Start	Month (ent	er 2-digit nur	2-digit number): 06			
	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)	\$	\$ 135	.00 \$ 13!	5.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code										L- 00705M				005 € (2004)		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Derrick Rich 1495 Sane Rd Se Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	vice		Go to www.i	rs.gov/Form	1095C for inst	tructions an	d the latest inf	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Derrick		Rich			XXX-XX-832	25	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
1495 Sane Ro	l Se						2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal			
Dalton		GΑ		US 307	21		Dalton		GA		US 30	721			
Part II Emp	loyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code			A Nation										005 0 (200)		

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

Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III Cover If Empl		red coverage, check th			on for e	each inc	lividual	enrolle					employe	e. \succeq		
	(a) Name of First name, m		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Jeff L Ridley 2011 Fullers Chapel Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, i	middle initial, last	: name)	2 Social s	security number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	on number (EIN)		
Jeff		L Ridley			XXX-XX-218	30	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartn	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
2011 Fullers Chapel Road							2055 Cleveland Hwy					7062593344			
4 City or town	City or town 5 State or province 6 Country					n postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal coo			
Chatsworth						30705 Dalto			GA		US 30	721			
Part II Employee Offer of Coverage Employee's Age						Age on J	anuary 1		Plan Start	Month (ent	Nonth (enter 2-digit number):				
All 12 Months Jan Feb Mar Ap						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	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	\$ 125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													005 0		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

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Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

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Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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Pa		loyer pro	vided self-insu	ured coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name o First name, r			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	of covera	Aug	Sept	Oct	Nov	Dec
18	Jeff	L	Ridley	XXX-XX-2180			\times	\times	\times	\times	\times	\times						
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Theresa L Ridley Po Box 602 Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www.i	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Theresa		L Ridley		\ \ \ \	(XX-XX-607	72	Campbell Pr	inting Com		5813669	97				
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
Po Box 602						2055 Cleveland Hwy						7062593344			
4 City or town	5	5 State or provin	се	6 Country a	and ZIP or foreign	postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Chatsworth	05		Dalton		GA		US 30	721							
Part II Employee Offer of Coverage Empl						Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
Part II Employee Offer of Coverage Employee's A All 12 Months Jan Feb Mar Apr 14 Offer of						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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	125.00	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0		

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

Cat. No. 60705M

Form 1095-C (2024)

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Filemon R Rodriguez 117 Bear Den Ct Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

RECTED 20**24**

Internal Revenue Service Go to www.irs.gov/Form1095C for instruction							I the latest info	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Employ	er Membe	r (Employe	er)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social se	ecurity number	(SSN) 7	7 Name of emplo	oyer			8 Empl	oyer identification	n number (EIN)	
Filemon		R Rodrigu	Jez	X	(XX-XX-66)	13 (Campbell Pr	inting Com	pany, Inc.			58136699	97	
3 Street address (i	ncluding apartm	nent no.)				9	Street address	(including room	or suite no.)		10 Conta	act telephone nu	mber	
117 Bear Den	Ct					2	2055 Clevela	and Hwy				70625933	44	
4 City or town					nd ZIP or foreigr	n postal code 1	1 City or town		12 State or prov	vince	13 Count	13 Country and ZIP or foreign po		
Dalton					US 30721				GA		US 30	US 30721		
Part II Emp						Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nu	r 2-digit number):		
	All 12 Months Jan Feb					May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	, , ,				1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00 \$	135.00	135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													005 0	

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Cat. No. 60705M

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

ANDREA ROGERS 208 Treefork Way Ringgold, GA 30736-9051

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	vice		GO to www	.irs.gov/For	m 1095C for in	structions ar	ia the latest ii	ntormation.							
Part I Emp	loyee						Α	pplicable L	arge Empl	loyer Memb	er (Emplo	/er)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
ANDREA		ROGE	ERS		XXX-XX-3	779	Campbell Printing Company, Inc.					58136	6997		
3 Street address (in	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
208 Treefork \	Nay						2055 Cleve	eland Hwy		7062593344					
4 City or town 5 State or province 6 Country and ZIP or foreign postal							e 11 City or town 12 State or province					intry and ZIP or	foreign postal code		
Ringgold GA US 30736-9051							Dalton GA					US 30721			
	loyee Offe	r of Cove	rage	•	Employee ³	s Age on	January 1		Plan Sta	rt Month (e	nter 2-digit n	2-digit number): 0			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D		
17 ZIP Code													1005.0		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

DANIEL RUBIO 3799 TIBBS BRIDGE RD DALTON, GA 30721

Form	10	95 -	·U
Depart	ment c	of the Tre	asury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Internal Revenue Ser	vice		Go to www.	irs.gov/For	<i>m10</i> 95C for in	195C for instructions and the latest information.										
Part I Emp	loyee						Α	pplicable L	arge Emplo	oyer Memb	er (Employ	/er)				
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identifica	ation number (EIN)			
DANIEL		RUBIC)		XXX-XX-7	558	Campbell F	Printing Com		581366997						
3 Street address (including apartment no.)							9 Street addre	ss (including roo	m or suite no.)		10 Cor	10 Contact telephone number				
3799 TIBBS BRIDGE RD							2055 Cleve	eland Hwy				7062593344				
4 City or town 5 State or province 6 Country and ZIP or foreign postal												intry and ZIP or	foreign postal code			
DALTON GA US 30721							Dalton GA US					JS 30721				
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	rt Month (er	nter 2-digit n					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2H			
17 ZIP Code			Act Notice and						N- 00705M				1005 C (2004)			

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

Cat. No. 60705M

Instructions for Recipient

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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20																
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Luis C Rubio 290 Springfield Drive Chatsworth, GA 30705

Form	109:	5-C
Departi	ment of the	Treasury
Intorna	I Dovonuo	Sorvico

Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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

VOID

Internal Revenue Ser	rvice		Go to www.i	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Luis	(C Rubio		>	XXX-XX-845	57	Campbell Pr	inting Com		581366997					
3 Street address (in	3 Street address (including apartment no.)							(including room	or suite no.)		10 Conta	10 Contact telephone number			
290 Springfield Drive							2055 Cleveland Hwy					7062593344			
4 City or town	5	State or province	се	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal code			
Chatsworth		GA		US 307	05		Dalton		GA		US 30	US 30721			
Part II Emp	oloyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	?-digit number): (
	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)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code			A Nation										005 0 (200)		

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

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Olga Rubio 3799 Tibbs Bridge Dalton, GA 30721

Form	109:	5-C
Departi	ment of the	Treasury
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CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		Go to www.ii	rs.gov/Form	1095C for insi	tructions an	a the latest int									
Part I Emp	oloyee						Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)			
Olga		Rubio)	XXX-XX-6307			inting Com		5813669	97					
3 Street address (in	ncluding apartm	ent no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number						
3799 Tibbs Br	799 Tibbs Bridge							and Hwy		7062593344						
4 City or town	5	State or provinc	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal				
Dalton		GA		US 307	US 30721				GA		US 30	US 30721				
Part II Emp	oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code													205.0			

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

MARIA SEBASTIAN 50 CLASSIC LN CHATSWORTH, GA 30705

Form	109:	5-C
Departi	ment of the	Treasury
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CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Se	rvice		Go to www	.irs.gov/Forn	<i>n10</i> 95C for in	structions ai	nd the latest in	itormation.								
Part I Emp	loyee						A	pplicable L	arge Emplo	yer Member	r (Employe	r)				
1 Name of employ	ee (first name, m	iddle initial, las	t name)	2 Social	security number	er (SSN)	7 Name of emp	oloyer			8 Emplo	yer identification	on number (EIN)			
MARIA		SEBA:	STIAN		XXX-XX-2503 Campbell Printing Company, Inc.							581366997				
3 Street address (i	ncluding apartme	ent no.)		•			9 Street addres	ss (including roor	n or suite no.)		10 Conta	10 Contact telephone number				
50 CLASSIC I	_N						2055 Cleve	land Hwy				70625933	344			
4 City or town	5	State or provi	nce	6 Country	y and ZIP or forei	gn postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal c				
CHATSWORT	гн 🤇	βA		US 30	US 30705				GA		US 30	721				
Part II Emp	loyee Offer	r of Cover	age		Employee	's Age on .	January 1		Plan Start	: Month (ente	er 2-digit nun	nber):	06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1H			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00 <i>\$</i>	3 125.00 \$	S 125.00	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	2H	2H	2H	2H	2A			
17 ZIP Code			Addition										1005 0 222			

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

Cat. No. 60705M

Form 1095-C (2024)

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

KRISTIE J SEIBER 1632 OAK HILL RD NW DALTON, GA 30721

Form 1095-	J
Department of the Treas	ury

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	vice		GO to www	.irs.gov/Forn	n 1095C for in	structions an	a the latest into	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	iddle initial, las	t name)	2 Social	security number	r (SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)	
KRISTIE	J	SEIBE	R		XXX-XX-74	135	Campbell Pr	inting Comp		5813669	97			
3 Street address (in	ncluding apartme	ent no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number				
1632 OAK HIL	632 OAK HILL RD NW							and Hwy		7062593344				
4 City or town	5	State or provin	nce	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal of		
DALTON	G	ŝΑ		US 30	US 30721				GA		US 30	US 30721		
Part II Emp	loyee Offer	of Cover	age		Employee'	s Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	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)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 135.00)\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00 <i>\$</i>	125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code													205.0	

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

BRADLEY SHERWOOD 476 Kirby Young Rd, Lot F DALTON, GA 30720

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

2024

Internal Revenue Se	ervice		Go to www.	tructions ar	nd the latest in										
Part I Em	ployee						Α	pplicable L	er (Emplo	yer)					
1 Name of employ	yee (first name,	middle initial, las	t name)	2 Social s	security number	(SSN)	7 Name of em	ployer			8 Em	8 Employer identification number (EIN			
BRADLEY		SHER'	WOOD		XXX-XX-03	62	Campbell I	Printing Con		581366997					
3 Street address (including apartment no.)							9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
476 Kirby Young Rd Lot F							2055 Cleve	eland Hwy		7062593344					
4 City or town 5 State or province 6 Country and ZIP or foreign postal country							11 City or town		12 State or pro	ovince	13 Co	13 Country and ZIP or foreign postal code			
DALTON GA US 30720							Dalton		GA	US:	30721				
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	t Month (er	nter 2-digit r	2-digit number): 06			
All 12 Months Jan Feb Mar Apr						May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$ 135.00	\$ 135.00	\$ 135.00	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2H	2H	2H	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Christopher M Smith 1910 Tibbs Terrace Dalton, GA 30720

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions an	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	er (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Christopher	r	M Smith		>	XXX-XX-88	58	Campbell Pr	inting Com		581366997					
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
1910 Tibbs Te	errace						2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or provinc	ce	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal cod			
Dalton		GA		US 307	20		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	: Month (ent	ter 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code			A Nation										00E C (200		

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

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Name of c	overed ir ddle initia	ndividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Christopher	M	Smith	XXX-XX-8858			\times	\boxtimes	\times	\times	X	X	X	X	X	X	X	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Kenneth L Smith 1018 Somerset Place Cohutta, GA 30710

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	loyee							Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle	e initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	on number (EIN)			
Kenneth		L	Smith		,	XXX-XX-63!	56	Campbell Pr	inting Com	pany, Inc.			5813669	97			
3 Street address (i	ncluding apartr	nent n	10.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
1018 Somerse	et Place							2055 Clevela	and Hwy				70625933	344			
4 City or town		5 Sta	te or provinc	ce	6 Country	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal code				
Cohutta		GΑ			US 307	'10		Dalton		GA		US 30	721				
Part II Emp	loyee Off	er of	f Covera	ge		Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nu	mber):	06			
	All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Oct	Nov	Dec					
14 Offer of Coverage (enter required code)			1E	1E	1E	1E	1E	June July Aug Sept 1E 1E 1E 1E				1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$	135.00	\$ 135.00\$	\$ 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code																	

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Danny L Sosebee 5004 Muse Rd Sw Resaca, GA 30735

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Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	oloyee						Ар	plicable La	arge Employ	yer Membe	r (Employe	r)			
1 Name of employ	/ee (first name, m	niddle initial, last	name)	2 Social se	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	on number (EIN)		
Danny		L Sosebe	е	X	(XX-XX-656	50	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	including apartm	ent no.)					9 Street address	(including room	10 Conta	10 Contact telephone number					
5004 Muse Ro	d Sw						2055 Clevela	and Hwy		7062593344					
4 City or town	5	State or provinc	ce	6 Country a	and ZIP or foreign	postal code	oostal code 11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
Resaca		GA		US 3073	35		Dalton GA					721			
Part II Emp	oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code															

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Cat. No. 60705M

Form 1095-C (2024)

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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III Covere			ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Danny	L	Sosebee	XXX-XX-6560	,		X	×	X	X	×	×	X	X	X	×	×	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

William C Sutton 22 Hoyt Drive Crandall, GA 30711

Form	095	5-C
Departm	ent of the	Treasury
Intornal	Davanua C	onvioo

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Sei	rvice		Go to www.ir	s.gov/Forr	<i>n10</i> 95C for in	istructions an	id the latest i	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social	security number	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
William		C Sutton			XXX-XX-6	940	Campbell I	Printing Con		58136	6997				
3 Street address (in	ncluding apartm	nent no.)					9 Street addre	ess (including roo	m or suite no.)		10 Co	10 Contact telephone number			
22 Hoyt Drive							2055 Cleve	eland Hwy		7062593344					
4 City or town								11 City or town 12 State or province 13					foreign postal code		
Crandall		GA		US 30	711		Dalton GA L					30721			
Part II Emp	oloyee Offe	er of Covera	ge		Employee	's Age on J	January 1		Plan Sta	rt Month (e	nter 2-digit r	iumber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 135.00	\$ 135.00 \$		\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code													1005 0		

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Cove	ered Indi ployer pro	viduals vided self-ins	ured coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name First name	of covered in	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Anr		Months June	of covera		Sept	Oct	Nov	Doo
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

KATHY TORRES 509 Falcon Cir Chatsworth, GA 30705-3185

Form 1095-C	
Department of the Treasury	
Internal Devenue Convice	

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Employe	r)			
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Emplo	yer identificatio	n number (EIN)		
KATHY		TORR	ES		XXX-XX-01	175	Campbell F	Printing Com		5813669	97				
3 Street address (i	ncluding apartme	ent no.)					9 Street addres	ss (including roo	m or suite no.)		10 Conta	10 Contact telephone number			
509 Falcon Ci	ir						2055 Cleve	eland Hwy		7062593344					
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province 13					ry and ZIP or fore	eign postal code		
Chatsworth		3A		US 30	705-3185		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on	January 1		Plan Sta	rt Month (er	nter 2-digit nur	nber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 125.00	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2H	2H	2H		
17 ZIP Code			A st Notice										00E C (200		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Karen Townsend 618 Salacoa Rd Ne Fairmount, GA 30139

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Internal	Rovenue Sen	/ica

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Service Go to www.irs.gov/Form1095C for Inst							a tne latest int	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)		
Karen		Townse	end	>	XX-XX-348	30	Campbell Pr	inting Com		581366997					
3 Street address (in	ncluding apartm	ent no.)		_			9 Street address	(including room	10 Conta	10 Contact telephone number					
618 Salacoa F	Rd Ne						2055 Clevel	and Hwy				7062593344			
4 City or town	5	State or provinc	ce	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal co			
Fairmount		GA		US 301	S 30139 Dalton GA						US 30	US 30721			
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
	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)	\$	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	\$ 125.00°	\$ 125.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

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You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

ELIJAH M VANDEWALKER 154 Rogers Rd Chatsworth, GA 30705-7925

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

internal Revenue Se	rvice		GO LO WW	w.irs.gov/i	-011111093	C IOI II	istructions an	u tile latest li	normation.			~ -				
Part I Emp	oloyee							Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial,	last name)	2 S	ocial securi	ty numbe	er (SSN)	7 Name of emp	oloyer			8 Ei	nployer identifi	cation number (EIN)		
ELIJAH		M VAN	DEWALKER	2	XXX	-XX-3	261	Campbell F	Printing Com		58136	6997				
3 Street address (i	including apartr	ment no.)		•				9 Street addres	ss (including roo	10 C	10 Contact telephone number					
154 Rogers R	?d							2055 Cleve	eland Hwy				70625	93344		
4 City or town		5 State or pro	ovince	6 Co	untry and ZI	IP or fore	ign postal code	11 City or town		12 State or pro	ovince	13 Co	13 Country and ZIP or foreign postal code			
Chatsworth		GA		US	30705-7	7925		Dalton GA					US 30721			
Part II Employee Offer of Coverage Employee's Age								January 1 Plan Start Month (enter 2					-digit number): 06			
	All 12 Months	Jan	Feb	Mar		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H		1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A		2A	2A	2A	2A	2D	2D	2A	2A	2A		
17 ZIP Code																

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Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

MANUELA ERENDIRA VAZQUEZ FRAIRE 200 Hewitt Dr Dalton, GA 30721-8718

Form	109:	5-C
Departi	ment of the	Treasury
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CORRECTED

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

Internal Revenue Ser	vice		Go to www.	irs.gov/For	m 1095C for in	structions ar	ia the latest ii	ntormation.							
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employe	ee (first name, n	niddle initial, la	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
MANUELA		e Vazo	UEZ FRAIRE		XXX-XX-19	959	Campbell Printing Company, Inc.					58136	6997		
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
200 Hewitt Dr							2055 Cleve	eland Hwy		7062593344					
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
Dalton		GA		US 30	721-8718		Dalton GA					US 30721			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit n	digit number): 06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D		
17 ZIP Code													1005.0		

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Sarahi Velasquez Villegas 1119 Ridgeleigh Circle Dalton, GA 30720

Form	109:	5-C
Departi	ment of the	Treasury
Intorna	I Dovonuo	Sorvico

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

2024

Internal Revenue Se	ervice			Go to www.i	rs.gov/Forn	ov/Form1095C for instructions and the latest information.											
Part I Em	ployee							Ap	plicable La	arge Employ	er Membe	r (Employ	Employer)				
1 Name of employ	yee (first name,	middle initi	al, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emp	loyer identificatio	on number (EIN)			
Sarahi		Ve	lasqu	uez Villegas		XXX-XX-84	69	Campbell Pr	inting Com	pany, Inc.			5813669	97			
3 Street address	including apartr	ment no.)		-				9 Street address	(including room	n or suite no.)		10 Contact telephone number					
1119 Ridgele	igh Circle							2055 Clevela	and Hwy				7062593344				
4 City or town		5 State or	provinc	се	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Cour	ntry and ZIP or fore	eign postal code			
Dalton		GA			US 307	720		Dalton		GA		US 3	US 30721				
Part II Em	ployee Off	er of Co	vera	ige		Employee's	Age on J	anuary 1		Plan Start	Month (ente	er 2-digit nı	-digit number):				
					Mar	Apr	May	June	July	Aug			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)	\$	\$ 13	5.00	\$ 135.00\$	S 135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		21-	l	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code																	

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Matthew Watts Po Box 505 Resaca, GA 30735

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

nternal Revenue Service Go to www.irs.gov/FormTo95C for inst							i ine iatest iini	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Matthew		Watts)	XXX-XX-530	08	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	ncluding apartm	ent no.)		_	9 Street address (including room or suite no.)						10 Conta	ct telephone nu	ımber	
Po Box 505]:	2055 Clevela	and Hwy				70625933	344	
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	tate or province 13 Country and ZIP or foreign				
Resaca					35]	Dalton		GA		US 30	US 30721		
Part II Emp	loyee Offe	r of Covera	nge						Plan Start	Month (ent	er 2-digit nun	nber):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May			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)	\$	\$ 135.00	\$ 135.00 \$	135.00	\$ 135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	125.00	\$ 125.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code														

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

Cat. No. 60705M

Form 1095-C (2024)

Instructions for Recipient

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Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

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Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Coverd If Emplo	ed Individuals byer provided se	elf-insured coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name. m	covered individual(s) iddle initial, last nam	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Matthew	Watts	XXX-XX-5308			X	X	×	X	×	X	X	X	Ж	X	X	X
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

MATTHEW S WIDENER 84 Griggs Rd Tunnel Hill, GA 30755-7892

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2024

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Part I Emp	oloyee						Aı	oplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, n	niddle initial, las	st name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	ation number (EIN)	
MATTHEW		S WIDEI	NER		XXX-XX-78	374	Campbell F	Printing Com		581366	997			
3 Street address (i	ncluding apartm	nent no.)		'			9 Street addres	ss (including roor	n or suite no.)		10 C	ontact telephone	number	
84 Griggs Rd							2055 Cleve	land Hwy				706259	3344	
4 City or town		5 State or provi	ince	6 Country	y and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13 Co	ountry and ZIP or	foreign postal code	
Tunnel Hill	(GA		US 30	755-7892		Dalton		GA		US	US 30721		
Part II Emp	oloyee Offe	er of Cover	rage	Employee'	s Age on	January 1		Plan Star	t Month (ei	nter 2-digit	2-digit number): 06			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2A	2A	2A	2A	
17 ZIP Code													1005.0	

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered. In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(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	Jan	Feb	Mar	Apr	(e) May) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Tracy L Willin 2952 Carol Circle Rocky Face, GA 30740

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Sei	vice		GO LO WWW.II	s.gov/Formi	1093C IOI IIISI	li uctions and	u the latest line	ormation.			I .					
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					8 Employer identification number (EIN)					
Tracy		L Willin		X	XXX-XX-8119			Campbell Printing Company, Inc.					581366997			
3 Street address (in	ncluding apartn	nent no.)					9 Street address (including room or suite no.)					10 Contact telephone number				
2952 Carol Ci	rcle						2055 Cleveland Hwy					7062593344				
4 City or town	;	5 State or province	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal code				
Rocky Face		GA		US 3074	US 30740				GA		US 30	US 30721				
Part II Emp	loyee Offe	er of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	-digit number): 06				
	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)	\$	\$ 135.00	\$ 135.00 \$	135.00	135.00	\$ 135.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00\$	S 125.00	\$ 125.00			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code									I- COZOSM				005 € (000.4)			

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

Cat. No. 60705M

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	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	Jan	Feb	Mar	Apr	(e) May	June	Months of covera		Sept	Oct	Nov	Dec
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30