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

Form <b>1095-C</b>
Department of the Treasury
Internal Revenue Service

## 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						Ар	plicable La	rge Employ	er 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)		
Obdulia		Barcena	as	\ \ \ \	XX-XX-43!	52	Campbell Pr	inting Com		581366997					
3 Street address (i	ncluding apartm	nent no.)					9 Street address	(including room	10 Conta	10 Contact telephone number					
410 Martha Si	ue Dr Apt C	,					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	13 Country and ZIP or foreign postal co			
Dalton	-	GA		US 307	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	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\{</i>	\$ 135.00		
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										005 0 (2000)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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- 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				on for e	ach 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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**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

Socorro Bejarano 220 S Grimes St Dalton, GA 30721

Form <b>1095-C</b>	
Department of the Treasury	
Internal Revenue Service	

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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,	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Socorro		Bejaran	10	<b>)</b>	(XX-XX-65 <sup>2</sup>	14	Campbell Pr	inting Com		581366997					
3 Street address (i	ncluding apartn	nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
220 S Grimes	St						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	13 Country and ZIP or foreign postal co			
Dalton		GA		US 307	21		Dalton		GA		US 30	US 30721			
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	2-digit number): 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)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0		

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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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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Arthur D Biles 1575 Threadmill Road Dalton, GA 30720

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

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OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	a the latest into	ormation.								
Part I Emp	oloyee						Ap	plicable La	rge Emplo	yer Membe	r (Employer	<u>r)</u>				
1 Name of employ	vee (first name, r	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Employ	yer identification	on number (EIN)			
Arthur		D Biles		>	XX-XX-45	11	Campbell Pr	inting Com	pany, Inc.			581366997				
3 Street address (i	including apartm	nent no.)		•			9 Street address	(including room	10 Contac	10 Contact telephone number						
1575 Threadn	nill Road						2055 Clevela	and Hwy		7062593344						
4 City or town	į	5 State or province	ce	6 Country a	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Country	13 Country and ZIP or foreign postal co				
Dalton		GA		US 307	20		Dalton		GA		US 307	US 30721				
Part II Emp	oloyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (ent	er 2-digit num	2-digit number):				
	All 12 Months Jan Feb					May	June	July	Aug	Sept	Oct	Nov	Dec			
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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.
- **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.
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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-insured				on for e	ach 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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## 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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 Blackburn 3688 Hurricane Rd Rocky Face, GA 30740

Form	<b>7</b> U	<i>)</i> 95	)-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

Internal Revenue Se	rvice		GO LO WWW	.irs.gov/rori	iniogoc for the	structions an	u the latest ii	normation.							
Part I Emp	oloyee						Α	pplicable La	er (Employ	er)					
1 Name of employ	ee (first name,	middle initial, last	t name)	2 Socia	I security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identificat	ion number (EIN)		
Tina		Blackb	urn		XXX-XX-1022			Printing Com		5813669	997				
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ss (including roor	<b>10</b> Cor	10 Contact telephone number					
3688 Hurricar	ne Rd						2055 Cleve	eland Hwy			7062593344				
4 City or town		5 State or provin	ice	6 Countr	y and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	<b>13</b> Cou	13 Country and ZIP or foreign postal code			
Rocky Face		GA		US 30	740		Dalton		GA		US 3	US 30721			
Part II Emp	oloyee Off	er of Cover	age		Employee's	s Age on J	anuary 1		Plan Start	t <b>Month</b> (er	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	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**

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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- 11. Reserved for future use.
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- **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-insured				on for e	ach 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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## 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Christian Bonds 127 Fannie St Dalton, GA 30720

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Form		U	J	U	_	U
Depar	tme	ent d	of th	ne T	rea	sury

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.ir	s.gov/Form	1095C for ins	tructions and	d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	er (Emplo	yer)					
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			<b>8</b> Er	nployer identifica	ation number (EIN)		
Christian		Bonds		>	XXX-XX-78	88	Campbell Pr	inting Com	pany, Inc.			581366997			
3 Street address (in	ncluding apartme	ent no.)				9 Street address	(including roon	n or suite no.)		<b>10</b> Co	10 Contact telephone number				
127 Fannie St	İ						2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	се	6 Country a	and ZIP or foreig	n postal code	11 City or town		12 State or pro	ovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Dalton		SA .		US 307	20		Dalton		GA		US	30721			
Part II Emp	loyee Offer	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Star	t 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)		1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2A	2A	2A	2A	2A		
17 ZIP Code									No. 00705M				1005 C (2000)		

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. 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.

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

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
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## Instructions for Recipient (continued)

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## Part III. Covered Individuals, Lines 18–30

Kera L Brewer 29 June Lane Ringgold, GA 30736

Form	095	5-C
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Intornal	Davanua C	onvioo

## 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/roilii	10930 101 1118	di uctions and	i tile latest lille	ormation.			I .				
Part I Emp	loyee						Ap	plicable La	r (Employe	er)					
1 Name of employe	ee (first name, i	middle initial, last	: name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	oyer identification	n number (EIN)		
Kera		L Brewer	•		XXX-XX-28	47 (	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartn	nent no.)				9	9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
29 June Lane					2			and Hwy		7062593344					
4 City or town	;	5 State or provin	ce	6 Country	and ZIP or foreig	n postal code 1	1 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code		
Ringgold		GA		US 307	36	[	Dalton		GA		US 30	721			
	loyee Offe	er of Covera	age	İ	Employee's	Age on Ja	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
<b>16</b> 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 A Nation						2070714				005 (2000)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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.

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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.

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

Pa	I <b>rt III</b> Covere		ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of of First name, mi		(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		Brewer	XXX-XX-2847			X	×	X	X	×	X	X	X	Х	X	×	X
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Page 4

Form 1095-C (2023)

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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

Larry R Brewer 1005 Glisson Dr Tunnel Hill, GA 30755

Form	10	<b>195</b>	-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.

2023

Internal Revenue Se	rvice		Go to www.irs	s.gov/Form	1095C for ins										
Part I Emp	loyee						Ap	plicable La	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)		
Larry	F	R Brewer			XXX-XX-47	57	Campbell Pr	inting Com		5813669	97				
3 Street address (i	ncluding apartme	ent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
1005 Glisson	Dr						2055 Clevela	and Hwy				7062593344			
4 City or town	5	се	and ZIP or foreigi	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code				
Tunnel Hill	0	ŝΑ		US 307	55		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 (ente	er 2-digit nun	nber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June July		Aug	Sept	Oct	Nov	Dec		
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<b>17</b> ZIP Code													005 0 200		

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Cat. No. 60705M

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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 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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#### Part III. Covered Individuals, Lines 18–30

Tony L Bryson 301 Frontier Trail Nw Dalton, GA 30721

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

VOID

OMB No. 1545-2251

Internal Revenue Service Go to www.irs.gov/Form1095C for instruction								ions an	s and the latest information.										
Part I Emp	art I Employee									Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle	initial, las	st name)	2 Soc	al security n	umber (SSN)	)	7 Name of emp	ployer			8 Er	nploye	r identificatio	n number (EIN)			
Tony		L	Brysor	า		XXX-X	X-6928		Campbell Printing Company, Inc.						581366997				
3 Street address (	including apartr	ment n	o.)						9 Street addres	ss (including roor	n or suite no.)		<b>10</b> C	10 Contact telephone number					
301 Frontier 7	301 Frontier Trail Nw								2055 Cleveland Hwy					7062593344					
4 City or town		5 Stat	te or provi	nce	6 Coun	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	ovince	<b>13</b> Co	ountry a	and ZIP or fore	eign postal code			
Dalton GA  Part II Employee Offer of Coverage						US 30721			Dalton		GA		US	3072	<u>2</u> 1				
Part II Emp	Cover	age		Emplo	yee's Ag	e on J	lanuary 1		Plan Star	t <b>Month</b> (en	ter 2-digit	numb	er):	06					
All 12 Months Jan Feb						Ap	r	May	June	July	Aug	Sept	Oct		Nov	Dec			
14 Offer of Coverage (enter required code)			1H	1H	1H	11-	1	1H	1H	1H	1H	1H	1H		1E	1E			
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<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	24	<b>A</b>	2A	2A	2A	2D	2D	2D		2H	2H			
17 ZIP Code																			

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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.
- **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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Shana Bunch 5140 Arnold Rd Ne Dalton, GA 30721

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Depar	tmer	nt of th	ne Tre	asury
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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

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

Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) XXX-XX-8551 Campbell Printing Company, Inc. Shana Bunch 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2055 Claydland Lly E140 Arnold Dd Na 7042502244

5140 Arnold F	Rd Ne						2055 Cleve	land Hwy		7062593344				
4 City or town		5 State or provin	ice	6 Countr	6 Country and ZIP or foreign postal code				12 State or pro	ovince	<b>13</b> Co.	untry and ZIP or t	foreign postal code	
Dalton		GA		US 30	US 30721				GA		US :	30721		
Part II Emp	oloyee Offe	er of Covera	age	,	Employee'	s Age on	January 1		Plan Star	t <b>Month</b> (er	nter 2-digit n	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	1E	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$ 135.00	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2D	2H	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**

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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- 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				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

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

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Interna	al Rev	enue	Servi	CA

## **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.	ırs.gov/Form	1095C for ins	tructions an	a the latest into	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Reynaldo		Calder	ron Vigil		XXX-XX-56	09	Campbell Pr	inting Com		5813669	97				
3 Street address (i	ncluding apartm	ent no.)		<u>.</u>			9 Street address	(including roon	n or suite no.)		10 Conta	10 Contact telephone number			
812 Red Clay	APT 2						2055 Cleveland Hwy					7062593344			
4 City or town	5	State or provi	nce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal of			
Dalton		GΑ		US 307	21		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Cover	age	E	Employee's Age on				Plan Start	: <b>Month</b> (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)		1H	1H	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$ 98.89	\$ 98.89	\$ 98.89	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													<b>005-C</b> (2022)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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.

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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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- **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-insured				on for e	ach 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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#### 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

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.

CORRECTED

VOID

OMB No. 1545-2251

2023

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

Internal Revenue Se	ervice		Go to www.ir	s.gov/Form	1095C for ins	tructions an	d the latest info	ormation.		· <del></del>			
Part I Emp	oloyee						Ap	plicable La	arge Employ	er Membe	er (Employe	er)	
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emp	oyer identificatio	n number (EIN)
Brian		L Campb	ell		XXX-XX-16	10	Campbell Printing Company, Inc.						97
3 Street address (i	including apartr	ment no.)				9 Street address				10 Cont	act telephone nu	mber	
431 Caldwell	Rd Se						2055 Clevela	and Hwy				70625933	44
4 City or town		5 State or provin	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 fore	ign postal code
Cleveland		TN		US 373	323	Dalton GA U					US 30	)721	
Part II Emp	oloyee Off	er of Covera	age		Employee's	Age on J	anuary 1		Plan Start	Month (en	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	9\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)  2C 2C		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code				oonorata in					I- 00705M				005 C (2000)

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- 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 <b>rt III</b> Covere			ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of of First name, mi			(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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**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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## **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**23** 

Internal Revenue Se	rvice		Go to www.ir	s.gov/Form	1095C for ins	tructions and	i the latest int	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	er (Employe	er)			
1 Name of employ	vee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identificatio	n number (EIN)		
Sonya		L Campb	ell	>	XX-XX-14	47 (	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	including apartm	ent no.)				!	9 Street address	(including room	10 Cont	10 Contact telephone number					
431 Caldwell	Rd						2055 Clevela	and Hwy			7062593344				
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	vince	13 Coun	13 Country and ZIP or foreign pos			
Cleveland	-	ΓΝ		US 373	US 37323 Dalton					GA US 30721					
Part II Emp	oloyee Offe	r of Covera	nge	Employee's Age on			anuary 1		Plan Start	Month (en	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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		

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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	Irt III Covere	ed Indi	<b>viduals</b> vided self-insure	ed coverage, check th			on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of First name, m	covered in 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	) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Timothy E Campbell 4278 Country Way Cohutta, GA 30710

Form <b>1095</b>	-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 Ser	vice			GO to www.n	s.gov/roilii	1095C IOI IIIS	di uctions and	u tile latest lill	ormation.			ı		
Part I Emp	loyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	er)	
1 Name of employe	ee (first name,	middle	e initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	n number (EIN)
Timothy		Ε	Campb	ell		XXX-XX-66	67	Campbell Pr	rinting Com	pany, Inc.			5813669	97
3 Street address (in	ncluding aparti	ment r	10.)					9 Street address	(including room	or suite no.)		10 Cont	act telephone nu	ımber
4278 Country	Way							2055 Clevela	and Hwy				70625933	344
4 City or town		5 Sta	te or provinc	ce	6 Country	and ZIP or foreigi	n postal code 1	11 City or town		12 State or pro	vince	13 Count	try and ZIP or for	eign postal code
Cohutta		GΑ			US 307	10		Dalton		GA		US 30	721	
Part II Emp	loyee Off	er of	f Covera	nge		Employee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (ent	er 2-digit nu	mber):	06
	All 12 Months	5	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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<b>16</b> 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				Not Notice and						2070514			_ 4	00F C (2000)

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Cat. No. 60705M

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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.

#### 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.
- **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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- **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.
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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.

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 30

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

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Form	IU	<b>195</b>	<b>-</b> U
Depar	tment	of the Tr	easury
Intern	al Ray	anua Sar	vice

## **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.

2023

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, mi	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)
Timothy	othy K Campbell XXX-XX-8845					45	Campbell Pr	inting Comp	oany, Inc.			5813669	97
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	ct 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 foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code
Chatsworth	G	SA .		US 307	05		Dalton		GA		US 30	721	
Part II Emp	loyee Offer	of Covera	ige	E	Employee's	Age on J	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\$</i>	135.00	\$ 135.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
<b>17</b> 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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- **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.
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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.
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- 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|Campbell Κ XXX-XX-8845 18 Timothy  $\times$  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ 19 Mikaela Campbell XXX-XX-5391  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Campbell James XXX-XX-9928 X |X||X||X| $\times$ |X||X|X |X||X||X||X|Alayne M Campbell XXX-XX-0610 22 23 24 25 26 27 28 29 30

#### 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

Kimberley A Cannon Po Box 2329 Chatsworth, GA 30705

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

internal Revenue Se	ervice			GO to www.ir	s.gov/roiiii	11095C IOI IIIS	tructions and	u trie latest illi	ormation.						
Part I Emp	oloyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle	e initial, last r	name)	2 Social s	security number (	(SSN)	7 Name of emplo	oyer			8 Empl	8 Employer identification number (EIN)		
Kimberley		Α	Cannon			XXX-XX-803	33	Campbell Pr	inting Com	pany, Inc.			581366997		
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Cont	act telephone nu	mber		
Po Box 2329								2055 Clevela	and Hwy				70625933	44	
4 City or town		5 Sta	te or province	е	6 Country	and ZIP or foreigr	n postal code	,					try and ZIP or fore	eign postal code	
Chatsworth		GA			US 307	705		Dalton GA				US 30	721		
Part II Emp	oloyee Off	er of	Coverage	ge		Employee's	Age on J	anuary 1		Plan Start	t <b>Month</b> (ent	er 2-digit nu	mber):	06	
	All 12 Months	3	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)	\$	\$	98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
<b>17</b> 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. 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.

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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			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		A	Cannon	XXX-XX-8033			X	×	X	X	×	X	×	X	X	$\boxtimes$	×	$\times$
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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

George Chapman 934 Ave F 6 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. Internal Revenue Service

Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	vee (first name, m	niddle initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identific	ation number (EIN)		
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3 Street address (i	including apartme	ent no.)		_			9 Street address				10 Conta	10 Contact telephone number			
934 Ave F 6							2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	ce	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Counti	y and ZIP or	foreign postal code		
Dalton		Dalton		GA		US 30721									
Part II Emp	oloyee Offe	r of Covera	ige		Employee's				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	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	9\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2A	2A		
17 ZIP Code For Privacy Act a									No. 60705M				1 <b>095-C</b> (2023)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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.
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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				on for e	ach ind	ividual	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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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Joshua Chapman 1330 Coogler Rd 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.

CORRECTED

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OMB No. 1545-2251

2023

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) Joshua Chapman XXX-XX-4356 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1330 Coogler Rd 2055 Cleveland Hwv 7062593344 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GA US 30721 Dalton GA US 30721 Dalton **Employee Offer of Coverage** Part II **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 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2D 2A 2D 2D 2H 2H 2H 2H code, if applicable) 2H 2H 2H 17 ZIP Code

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

Cat. No. 60705M

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- 1Y. Reserved for future use.
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Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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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#### 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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## 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.

Maria D Chavarria Fraire XXX-XX-0857 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 Hwy 7062593344  4 City or town 5 State or province GA US 30720 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 Jan Feb Mar Apr May June July Aug Sept Oct Nov II  Coverage (enter required code) 1 E I E I E I E I E I E I E I E I E I E	internal Revenue Sel	rvice		GO LO WWW.I	is.gov/Foilii	1095C IOI IIIS	u ucuons an	u tile latest lill	ormation.							
Maria D   Chavarria Fraire   XXX-XX-0857   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 Hwy   7062593344   4 City or town   5 State or province   6 Country and ZIP or foreign postal code   11 City or town   2 State or province   13 Country and ZIP or foreign postal code   10 S 30720   Dalton   GA   US 30720   Dalton   GA   US 30721    Part II Employee Offer of Coverage   Employee's Age on January 1   Plan Start Month (enter 2-digit number): 06   Oct   Nov   It   Oct   Oc	Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	er (Employe	er)			
3 Street address (including apartment no.)  101 Pamala St  2055 Cleveland Hwy  7062593344  4 City or town Dalton  Fart II Employee Offer of Coverage    Employee's Age on January 1   September   Sept	1 Name of employ	/ee (first name, r	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emple	oyer	8 Emplo	8 Employer identification number (EIN)					
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Part II   Employee Offer of Coverage	4 City or town	5	5 State or province	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	ry and ZIP or for	eign postal code		
All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov   In the control of the coverage (enter required code)   1E   1E   1E   1E   1E   1E   1E   1	Dalton		GA		US 307	20		Dalton		GA		US 30	721			
14 Offer of Coverage (enter required code)         1E         1E<	Part II Emp	oloyee Offe	er of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (ent	ter 2-digit nur	'-digit number):			
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Required Contribution (see instructions) \$ 98.89 \$ 98.89 \$ 98.89 \$ 98.89 \$ 98.89 \$ 135.00 \$ 1	Coverage (enter		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
Safe Harbor and Other Relief (enter code, if applicable)  2H 2H 2H 2H 2H 2H 2H 2H 2H 2H 2H 2H 2H	Required Contribution (see	\$	\$ 98.89	\$ 98.89\$	S 98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
17 ZIP Code	Safe Harbor and Other Relief (enter		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**

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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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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 (2023)

#### 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

Eddie J Clayton 142 Athens Way Dalton, GA 30721

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OMB No. 1545-2251

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

2023

Internal Revenue Sei	vice		GO to www.	ırs.gov/Fori	miugoc for in	structions ar	ia the latest ini	ormation.								
Part I Emp	loyee						Ap	plicable La	arge Emplo	yer Membe	er (Employ	er)				
1 Name of employ	ee (first name, n	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of empl	oyer			8 Em	oloyer identifica	ation number (EIN)			
Eddie		J Clayto	n		XXX-XX-62	221	Campbell Printing Company, Inc.					581366997				
3 Street address (i	ncluding apartm			<u>'</u>			9 Street address	(including roon	n or suite no.)		<b>10</b> Cor	10 Contact telephone number				
142 Athens W	ay						2055 Cleveland Hwy					7062593344				
4 City or town	5	5 State or provi	nce	6 Country	ry and ZIP or foreign postal code 11 City or town 12 State or province			<b>13</b> Cou	ntry and ZIP or	foreign postal code						
Dalton	(	GA		US 30	721		Dalton		GA		US 3	0721				
Part II Emp	loyee Offe	er of Cover	age	·	Employee <sup>3</sup>	s Age on .	January 1		Plan Start	Month (ent	ter 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	1E	1E	1E	1E	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D	2H	2H	2H	2H	2A	2A	2A			
17 ZIP Code													1005.0			

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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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Gary S Coker 142 Woody Pond Way Dalton, GA 30721

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OMB No. 1545-2251

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2023

Internal Revenue Ser	vice		Go to www.ii	rs.gov/Form	1095C for ins	tructions an	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	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Gary		S Coker			XXX-XX-13	53	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartm	ent 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	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 posta			
Dalton		GΑ		US 307	0721 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		
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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-insured				on for e	ach 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											Guly	Aug	Зерг			
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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Form 1095-C	1
Department of the Treasury	y
Internal Revenue Service	

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/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Membe	r (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)		
John		Collett	te		XXX-XX-0	960	Campbell F	Printing Com		5813669	97				
3 Street address (i	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Conta	10 Contact telephone number			
2018 Clematis	s Dr						2055 Cleve	eland Hwy		7062593344					
4 City or town	5	State or provi	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13 Countr	y and ZIP or fore	eign postal code		
Hixson	-	ΓΝ		US 37	<b>'</b> 343		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Cove	rage		Employee	's Age on c	January 1		Plan Star	<b>t Month</b> (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)		1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 135.00	\$ 135.00\$	\$ 135.00	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	2D	2C	2C	2C	2C		
17 ZIP Code			AdMatia										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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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 Covere		ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. 🗵		
	(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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#### 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

Jerry W Cross Jr Po Box 2022 Chatsworth, GA 30705

Form	109:	5-C
Departi	ment of the	Treasury
Intorna	I Dovonuo	Sorvico

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 Service Go to www.irs.gov/Form1095C for i							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	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Jerry	V	N Cross			XXX-XX-27	67	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartm	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
Po Box 2022							2055 Clevel	and Hwy		7062593344					
4 City or town	5	State or province	ce	6 Country	and ZIP or foreigi	n postal code	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code		
Chatsworth		GA		US 307	05		Dalton		GA		US 30	721			
Part II Emp	loyee Offe	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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			No. A. No. A. C.										00E C (2000)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

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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.
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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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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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Pa	rt III Cover	<b>ed Indi</b> loyer pro	<b>viduals</b> vided self-insu	red coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, n	f covered in niddle 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	) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Jerry	W	Cross	XXX-XX-2767			$\times$	$\times$	$\times$	$\times$	X	$\times$	X	$\boxtimes$	X	$\times$	$\times$	$\times$
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#### 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 J Deere 7 Tramore Ct Cartersville, GA 30120

Form	U9:	5-U
Departm	ent of the	Treasury
Internal	Ravanua (	Sarvica

# 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 nevertue Sei	vice		ao to www.n	s.govn onn	10300 101 1113	ti uctions and	ins and the latest information.										
Part I Emp	loyee						Ар	plicable La	rge Employ	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)				
William		J Deere		) ×	(XX-XX-25	53	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	10 Contact telephone number					
7 Tramore Ct							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 Countr	y and ZIP or fore	eign postal code				
Cartersville		GA		US 3012	20		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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00				
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**

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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.

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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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- **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-insured				on for e	ach 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

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

Form <b>1095-</b> C	
Department of the Treasury	
Internal Revenue Service	

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.

RRECTED 2023

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for ins									
Part I Emp	oloyee						Apı	plicable La	arge Emplo	yer Membe	r (Employer	<u>r)</u>		
1 Name of employ	vee (first name, r	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Employ	yer identification	n number (EIN)	
Larry		E Dent		) ×	(XX-XX-76	47	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	including apartm	ent no.)					9 Street address	(including room	10 Contac	10 Contact telephone number				
780 Wood Gre	ove Circle						2055 Clevela	and Hwy		7062593344				
4 City or town	5	State or provin	ce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Country	and ZIP or for	eign postal code	
Hixson	-	TN		US 373	43		Dalton		GA		US 307	721		
Part II Emp	oloyee Offe	r of Covera	age	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00	
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

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Pa	irt III C	<b>overed In</b> Employer p	<b>div</b> rov	<b>iduals</b> ided self-insu	ıred c	coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> 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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Page 4

Form 1095-C (2023)

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Charles T Duncan 175 Relic Way Dalton, GA 30721

Form <b>1095-</b> C	
Department of the Treasury	
Internal Davisaria Camilea	

## **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.

2023

Internal Revenue Sei	rvice		Go to www.ii	s.gov/Form	1095C for ins	tructions an	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, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	8 Employer identification number (EIN)		
Charles	-	T Duncan	1	<b>\</b>	XX-XX-469	98	Campbell Printing Company, Inc.					581366997		
3 Street address (in	ncluding apartm	ent no.)					9 Street address (including room or suite no.)					10 Contact telephone number		
175 Relic Way	175 Relic Way							and Hwy				70625933	44	
4 City or town 5 State or province 6 Country and ZIP or foreign						n postal code	11 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	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	<b>Month</b> (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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\{</i>	\$ 135.00	
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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- **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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Form <b>1095-</b> C
Department of the Treasury
Internal Revenue Service

## **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.

2023 Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Lamar Dunn XXX-XX-9082 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 231 Doctor Johnson Rd 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 Crandall US 30711 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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 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**

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach 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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#### 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

Elijah R Ellison 26Th 2Nd Street Flintstone, GA 30725

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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.

2023

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for in	istructions ar	id the latest ii	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security numbe	er (SSN)	7 Name of employer 8					nployer identific	ation number (EIN)	
Elijah		R Ellison			XXX-XX-3	946	Campbell Printing Company, Inc.					581366997		
3 Street address (i	ncluding apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number		
26Th 2Nd Stre	eet						2055 Cleve	eland Hwy				706259	3344	
4 City or town	5	State or province	ce	6 Country	and ZIP or fore	ign postal code	11 City or town		12 State or p	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Flintstone		GA		US 307	25		Dalton GA L					US 30721		
Part II Emp	oloyee Offe	r of Covera	ige		Employee	's Age on .	lanuary 1		Plan Sta	rt Month (e	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)		1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	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

## **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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

#### 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).
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- 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-insured				on for e	ach 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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#### 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

James Fowler 5974 Springplace 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.

VOID

OMB No. 1545-2251

Internal Revenue Ser	le Service Go to <i>www.irs.gov/Form1095C</i> 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)	
James		Fowler		>	XX-XX-094	40	Campbell Pr	inting Com		5813669	97			
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber	
5974 Springpl	5974 Springplace Rd Se								2055 Cleveland Hwy					
4 City or town	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code				
Cleveland TN US 37323							Dalton		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			
	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\</i>	\$ 135.00	
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 € (0000	

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

Cat. No. 60705M

## **Instructions for Recipient**

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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

#### Instructions for Recipient (continued)

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Leon E Fowler 3895 Dunnagan 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.

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OMB No. 1545-2251

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Leon Ε Fowler XXX-XX-9621 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 3895 Dunnagan Rd 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 Rocky Face US 30740 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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

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	(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
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Tristan Fowler 260 25Th St Ne, BUILDING 2 APT 1321 Cleveland, TN 37311

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CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Se	ervice		Go to www	.irs.gov/Fort	<i>n10</i> 95C for ins	structions ar								
Part I Emp	ployee						A	oplicable L	arge Emplo	yer Memb	er (Employ	/er)		
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Social	l security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	tion number (EIN)	
Tristan		Fowler			XXX-XX-8725			rinting Com		581366	997			
3 Street address (i	including apartr	ment no.)					9 Street addres	ss (including roo	<b>10</b> Co	Contact telephone number				
260 25Th St N	Ne BUILDI	NG 2 APT 1	321				2055 Cleve	land Hwy		7062593344				
4 City or town		5 State or proving	nce	6 Country	6 Country and ZIP or foreign postal code				12 State or province 13			3 Country and ZIP or foreign postal code		
Cleveland		TN		US 37	37311 Dalton			GA		US 3	30721			
Part II Emp	ployee Off	er of Cover	age		Employee's	s Age on c	lanuary 1		Plan Star	<b>t Month</b> (er	iter 2-digit n	umber):	06	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
<b>14</b> Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	2A	2A	2A	2A	2A	
<b>17</b> ZIP Code														

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Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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 (2023)

#### 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

Dakota S Fox 128 Nichols Lane 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

2023

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) Dakota S Fox XXX-XX-4974 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 128 Nichols Lane 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 **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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C code, if applicable) 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- 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.

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	(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
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#### Part III. Covered Individuals, Lines 18–30

Gilberto Fraire 1213 Vanderbilt Dr Dalton, GA 30720

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

CORRECTED

VOID

OMB No. 1545-2251

ment of the Treasury

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

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

RRECTED 2023

Internal Revenue Se	rvice		Go to www.ii	rs.gov/For	<i>m10</i> 95C for in	structions an	d the latest ir	nformation.							
Part I Emp	oloyee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 Er	nployer identifica	ation number (EIN)		
Gilberto		Fraire			XXX-XX-3	960	Campbell Printing Company, Inc.					581366997			
3 Street address (i	3 Street address (including apartment no.) 9 Street address (including room or suite no.)									<b>10</b> Co	ontact telephone	number			
1213 Vanderb	oilt Dr						2055 Cleve	eland Hwy				706259	3344		
4 City or town 5 State or province 6 Country and ZIP or foreign posta						gn postal code	11 City or town		12 State or pr	ovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Dalton		3A		US 30	720		Dalton GA					30721			
Part II Emp	oloyee Offe	r of Covera	ige		Employee	s Age on J	lanuary 1		Plan Star	t 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)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$		\$	\$	\$	\$	\$	\$	\$	\$	\$		
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			Not Notice and										1005 C (2000)		

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-insured				on for e	ach 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

Juan J Fraire 101 Pamala St Dalton, GA 30720

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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.

2023

Internal Revenue Se	vice		Go to www.irs.gov/Form1095C for instructions and the latest information.											
Part I Emp	loyee						Ар	plicable La	arge Employ	yer Membe	er (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)	
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3 Street address (i	ncluding apartm	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
101 Pamala S		2055 Clevela	and Hwy				70625933	344						
4 City or town 5 State or province 6 Country and ZIP or foreign posta							, , , , , , , , , , , , , , , , , , , ,				13 Countr	y and ZIP or fore	eign postal code	
Dalton GA US 30720							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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00°	\$ 135.00	
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. 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.

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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	109:	5-C
	ment of the	

## **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

ORRECTED | 20

Internal Revenue Ser	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	the latest inf	ormation.								
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	er (Employe	mployer)				
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emp	loyer identificatio	n number (EIN)			
Jonathan	/	A Freema	an		XXX-XX-33	(X-3332 Campbell Printing Company, Inc.						5813669	97			
3 Street address (in	ncluding apartm	ent no.)				9	9 Street address	(including roon	10 Cont	10 Contact telephone number						
4506 Bluffwoo	od Way						2055 Clevel	and Hwy			7062593344					
4 City or town	5	State or provin	ce	6 Country and ZIP or foreign postal code			1 City or town		12 State or pro	vince	13 Coun	13 Country and ZIP or foreign postal of				
Cohutta		GA		US 307	10	1	Dalton		GA		US 30	0721				
Part II Emp	oloyee Offe	r of Covera	age	E	Employee'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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00			
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												- 1	005 (2000)			

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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.

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

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Pa	I <b>rt III</b> Covere If Emplo	ed Indi	<b>viduals</b> vided self-insur	ed coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered in	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
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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Norma C Freitez 304 N Tibbs Rd Dalton, GA 30720

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

CORRECTED

VOID

OMB No. 1545-2251

**2023** 

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.ir	s.gov/Form	1095C for ins	tructions and	the latest infe	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Employ	yer Membe	er (Employe	er)			
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN) 7	Name of emplo	oyer			8 Empl	oyer identificatio	n number (EIN)		
Norma	(	C Freitez			XXX-XX-02	88 (	Campbell Pr	inting Com		581366997					
3 Street address (in	cluding apartme	ent no.)		'		9	Street address	(including room	10 Cont	10 Contact telephone number					
304 N Tibbs R	d					2	2055 Clevela	and Hwy			7062593344				
4 City or town	5	State or province	се	6 Country and ZIP or foreign postal code			1 City or town		12 State or pro	vince	13 Count	try and ZIP or fore	eign postal code		
Dalton		GA		US 307	20	[	Dalton		GA		US 30	721			
Part II Emp	loyee Offe	r of Covera	ige	E	Employee'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	Aug Sept		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									I- COZOSM				005 € (2000)		

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-insured				on for e	ach ind	ividual	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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

James M Garrett 5001 Upper River Road Charleston, TN 37310

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Department	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.

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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	arge Employ	yer Membe	r (Employe	r)			
1 Name of employ	vee (first name,	middle initial, last	: name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
James		M Garrett		<b>)</b>	(XX-XX-20 <sup>-</sup>	76	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	including apartr	ment no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
5001 Upper R	River Road				2055 Cleveland Hwy							7062593344			
4 City or town		5 State or provin	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			
Charleston		TN		US 373	10		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	nber):	06		
	All 12 Months Jan Feb Mar Apr							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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	135.00	\$ 135.00		
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

## **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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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 C	<b>overed I</b> Employer	ndiv prov	<b>riduals</b> rided self-insur	ed coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> Na First na	ame of cover ame, middle	red 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
18	James		M	Garrett	XXX-XX-2076	,		X	X	X	X	×	X	X	X	Х	×	X	X
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#### Instructions for Recipient (continued)

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

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OMB No. 1545-2251

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

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Internal Revenue Ser	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	d the latest inf	ormation.						
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	er (Employ	er)		
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emple	oyer	8 Emp	loyer identificatio	n number (EIN)			
Danny		Godfre	У		XXX-XX-81	24	Campbell Pr	inting Com		581366997				
3 Street address (i	ncluding apartm	nent no.)				9 Street address	(including room	n or suite no.)		<b>10</b> Cont	10 Contact telephone number			
350 Ceder Sp	rings Rd Se	Э					2055 Clevel	and Hwy				70625933	344	
4 City or town	5 State or provin	n postal code	11 City or town		12 State or pro	vince	13 Cour	try and ZIP or fore	eign postal code					
Cleveland	-	TN		323		Dalton		GA		US 30	0721			
Part II Emp	er of Covera	Age on J	anuary 1		Plan Start	Month (en	ter 2-digit nu	ımber):	06					
	All 12 Months	Jan	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	
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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- 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				on for e	ach 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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#### Instructions for Recipient (continued)

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#### 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**

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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.

2023

Internal Revenue Sei	rvice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	tne latest into	ormation.							
Part I Emp	oloyee						Ap	plicable La	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 identificatio	n number (EIN)		
Alba		Gomez			XXX-XX-53	42	Campbell Pr	inting Comp		5813669	97				
3 Street address (in	ncluding apartme	ent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
211 S Grimes	Street					1:	2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton	G	ŝΑ		US 307	21		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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
<b>17</b> 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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#### Part I. Applicable Large Employer Member (Employer)

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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.

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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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- 1Z. Reserved for future use.

Pa	art III Co	overed Indiv Employer pro	<b>viduals</b> vided self-insu	red coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> Nar First nar	me of covered in me, middle initial	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	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Alba		Gomez	XXX-XX-5342	,		X	X	×	X	×	X	×	X	X	$\times$	×	$\times$
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Mirna B Gomez 315 S Grade Drive Dalton, GA 30721

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.

2023

internal Revenue Sel	rvice		GO to www.ir	s.gov/roiiii	10930 101 1118	tructions and	i ine iatest iini	ormation.							
Part I Emp	loyee						Ap	r (Employe	r)						
1 Name of employ	ee (first name, r	niddle initial, las	t name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Mirna		B Gomez	7		XXX-XX-73	27	Campbell Pr	inting Com		5813669	97				
3 Street address (i	ncluding apartn	nent no.)			!	9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
315 S Grade I	Orive					]:	2055 Clevela	and Hwy				7062593344			
4 City or town		5 State or provin	nce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign post			
Dalton		GA		US 307	21		Dalton		GA		US 30	US 30721			
Part II Emp	loyee Offe	er of Cover	age	E	Employee's	Age on J	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\$</i>	135.00	\$ 135.00		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
<b>17</b> ZIP Code															

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Pa	rt III Covere If Emplo			red coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. $\succeq$		
	(a) Name of ( First name, mi			(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			X	×	×	X	×	×	X	X	X	$\boxtimes$	×	$\times$
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Michael Gonzalez 536 Reed Rd Apt A Dalton, GA 30720

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

VOID

OMB No. 1545-2251

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Internal Revenue Sei	rvice		Go to www.ir	s.gov/rorm	1095C for ins	tructions and	i the latest ini	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	er (Employe	er)	,		
1 Name of employ	vee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer	8 Empl	oyer identificatio	n number (EIN)				
Michael		Gonzal	ez	XXX-XX-1381			Campbell Printing Company, Inc.					581366997			
3 Street address (i	including apartm	ent no.)				9	9 Street address	(including room	n or suite no.)		10 Cont	10 Contact telephone number			
536 Reed Rd	Apt A						2055 Clevela	and Hwy				70625933	344		
4 City or town						n postal code 1	1 City or town		12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code		
Dalton	US 307	20		Dalton		GA		US 30	721						
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (en	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		
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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													205.0		

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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.
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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.

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 (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN 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  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ |X| $|\times|$ |X|18 Michael Gonzalez XXX-XX-1381  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ |X|XXX-XX-8309 19 Talia Gonzalez 20 21 22 23 24 25 26 27 28 29 30

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

CORRECTED

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OMB No. 1545-2251

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2023

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) Rosalba Gonzalez De Ponce XXX-XX-0990 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 1726 Walton Street 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 Dalton GA US 30721 Dalton GA US 30721 **Employee Offer of Coverage** Part II **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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 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**

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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				Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### 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

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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. Go to www irs gov/Form1095C for instructions and the latest information

VOID

OMB No. 1545-2251

Internal Revenue Se	structions ar	nd the latest in	formation.												
Part I Em	oloyee	-					Ap	plicable La	r (Employer	·)					
1 Name of employ	ee (first name,	middle initial, la	ıst name)	2 Soci	al security numbe	er (SSN)	7 Name of emp	oyer	8 Employ	er identification	on number (EIN)				
Christopher		Grace	9		XXX-XX-3879			rinting Com	pany, Inc.			581366997			
3 Street address (	including apart	ment no.)		<u>'</u>			9 Street address	s (including room	n or suite no.)		10 Contac	10 Contact telephone number			
741 Old Land	fill Rd						2055 Clevel	and Hwy				70625933	344		
4 City or town	4 City or town 5 State or province					ign postal code	11 City or town		12 State or pro	vince	13 Country	and ZIP or for	eign postal code		
Chatsworth GA					0705		Dalton		GA		US 307	<sup>7</sup> 21			
Part II Emp	oloyee Off	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Start	: Month (ent	er 2-digit num	2-digit number):			
	All 12 Months	s Jan	Feb	Mar	Apr May		June July		Aug	Sept	Oct	Oct Nov			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E		
<b>15</b> Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	135.00	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code													005 0 2222		

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. 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.

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- 1Z. Reserved for future use.

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	(a) Name of confirst name, mid	overed individual(s) Idle 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
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Albert Griffin 688 Lake Katherine Rd 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.

**CORRECTED** 

VOID

OMB No. 1545-2251

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Albert Griffin XXX-XX-9537 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 Hwy 7062593344 688 Lake Katherine Rd 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 Tunnel Hill US 30755 Dalton GA US 30721 **Employee Offer of Coverage** Part II 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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 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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	(a) Name of First name, n	f covered individual(s) niddle 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
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Karen Harris 111 Driver Lane Cohutta, GA 30710

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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.ii	s.gov/Form	11095C for in	structions an	id the latest ir	nformation.						
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)		
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social	security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)	
Karen		Harris			XXX-XX-56	559	Campbell Printing Company, Inc.					581366997		
3 Street address (including apartment no.) 9 Street address (in					ss (including roo	m or suite no.)		<b>10</b> Cor	O Contact telephone number					
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4 City or town	5	State or province	ce	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Cou	intry and ZIP or	foreign postal code	
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14 Offer of Coverage (enter required code)		1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	
17 ZIP Code			- A Madian										1005 C (2222	

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

Cat. No. 60705M

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#### Part III. Covered Individuals, Lines 18–30

Joseph S Headrick 2715 Brooks Drive 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.

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OMB No. 1545-2251

2023

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) Joseph S Headrick XXX-XX-6841 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 Hwy 7062593344 2715 Brooks Drive 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 Rocky Face GA US 30740 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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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	(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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**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

David F Higgins Jr 1108 Walston Street, Apt D208 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.

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Se	ervice			Go to www.	rs.gov/Forn	n1095C for ins	tructions and	d the latest info	ormation.							
Part I Em	ployee							Apı	plicable La	arge Employ	er Membe	r (Employ	er)			
1 Name of employ	yee (first name,	middle	initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	yer			8 Emp	oloyer identification	n number (EIN)		
David		F	Higgins			XXX-XX-31	83	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (	including apartr	ment n			'			9 Street address	(including room	n or suite no.)		<b>10</b> Con	10 Contact telephone number			
1108 Walstor	n Street Apt	D20	8(				1:	2055 Clevela	and Hwy				7062593344			
4 City or town	•	5 Stat	te or provinc	се	6 Country	6 Country and ZIP or foreign postal code			•	12 State or pro	vince	13 Cour	ntry and ZIP or fore	eign postal code		
Dalton		GΑ			US 307	720		Dalton		GA		US 3	US 30721			
Part II Em	ployee Off	er of	Covera	ige		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)	\$	\$	98.89	\$ 98.89	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
<b>16</b> 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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.
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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				on for e	ach ind	ividual	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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#### Instructions for Recipient (continued)

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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.

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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							pplicable	Large Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, n	niddle initial, last	name)	2 Social s	security number (	(SSN)	7 Name of en	ployer			8 Emplo	yer identificati	on number (EIN)		
Jackie		D Higgins			XXX-XX-445	53	Campbell	Printing Co	mpany, Inc.			5813669	97		
3 Street address (in	ncluding apartm	ent no.)					9 Street addr	ess (including re	oom or suite no.)		10 Conta	10 Contact telephone number			
1104 Walston	St Apt B 20	08				2055 Clev	eland Hwy				7062593	344			
4 City or town		State or province	ce	6 Country and ZIP or foreign postal code			11 City or town	1	12 State or pro	ovince	13 Countr	13 Country and ZIP or foreign postal code			
Dalton	(	GA		US 307	720		Dalton		GA		US 30	US 30721			
Part II Emp	loyee Offe	r of Covera	ge		Employee's	Age on c	January 1		Plan Star	t 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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.8	9 \$ 135.0	0\$ 135.	00 \$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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 a	nd Dansen	d. Dodustics A	A Nation						t No 60705M				095-C (2023		

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Cat. No. 60705M

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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	e. 🗵		
	(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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#### Instructions for Recipient (continued)

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#### 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**

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.

2023

Internal Revenue Ser	vice		Go to www.ii	rs.gov/Form	1095C for ins	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)		
Joe	V	V Higgins			XXX-XX-282	(XX-XX-2829 Campbell Printing Company, Inc.						581366997			
3 Street address (in	ncluding apartme	ent no.)		'			9 Street address	(including room	10 Conta	10 Contact telephone number					
1132 Smyrna	Church Roa	ad					2055 Clevel	and Hwy		7062593344					
4 City or town	5	State or province	се	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal coo			
Chatsworth		GΑ		US 307	05		Dalton		GA		US 30	US 30721			
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	-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		
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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													00E C (2000)		

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.

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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.

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

Pa	art III	Covered If Employ	d Indi er pro	<b>viduals</b> vided self-insu	red coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a Fir	) Name of co	overed in	idividual(s)	(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	Aug	Sept	Oct	Nov	Dec
18			W	Higgins	XXX-XX-2829			X	X	X	X	X	X	X	X	X	X	×	X
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Page 4

Form 1095-C (2023)

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#### Part III. Covered Individuals, Lines 18–30

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

Form	10	<b>95</b> -	·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.

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VOID

OMB No. 1545-2251

artment of the Treasury

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

PRRECTED 202

Internal Revenue Ser	nue Service Go to www.irs.gov/Form1095C for instructions and the latest information.													
Part I Emp	loyee						Applicable Large Employer Member (Employer)							
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of employer 8 i					8 Employer identification number (EIN)		
Tina		ທ │Higgins	;		XX-XX-90!	54	Campbell Printing Company, Inc.					581366997		
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
1116 Willowdale Rd NW Ste 215							2055 Clevela	and Hwy				70625933	344	
4 City or town	5	State or provin	ce	6 Country a	and ZIP or foreigi	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 307	20		Dalton		GA		US 30	721		
Part II Emp	loyee Offe	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (ente	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	S 135.00 S	S 135.00	\$ 135.00	
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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Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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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Kenneth L Holland 643 Champagne Trail Dalton, GA 30721

Form	U9:	5-U
Departm	ent 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.

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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						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	security number	(SSN)	Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
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3 Street address (in	ncluding apartm	ent no.)				٤	Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
643 Champag	ne Trail					[2	2055 Clevela	and Hwy				70625933	344		
4 City or town	5	State or provin	се	6 Country	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	vince	13 Count	ry 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	age		Employee's	Age on Ja	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		
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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			l l						2070714			- 4	005 (2 (2000)		

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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.

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Page 3 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-5435 21 22 23 24 25 26 27 28 29

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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**

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.

2023

Internal Revenue Se	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	arge 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 employer 8					yer identificatio	n number (EIN)	
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3 Street address (i	ncluding apartm	ent no.)					9 Street address (including room or suite no.)						mber	
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4 City or town 5 State or province 6 Country and ZIP or foreign posta						n postal code	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code	
Dalton		GA		US 307	21		Dalton		GA		US 30	721		
Part II Emp	oloyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	<b>Month</b> (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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\{</i>	\$ 135.00	
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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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**

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.

2023

Internal Revenue Se	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	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Michael		E Howard	ł		XXX-XX-77	30	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	ncluding apartm	nent no.)					9 Street address	(including room	10 Conta	10 Contact telephone number					
101 Timberva	le Drive				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 Count	13 Country and ZIP or foreign postal c			
Dalton	(	GA		US 307	US 30721				GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	<b>Month</b> (ent	er 2-digit nur	?-digit number):			
	All 12 Months Jan Feb Mar Apr I						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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00°	\$ 135.00		
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

## **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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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).
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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.
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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			ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of of First name, mi			(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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#### 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

Johnny E Ison 264 Loudermilk 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.

2023

Internal Revenue Sei	vice		GO LO WWW.II	s.gov/Form	10950 101 1115	u ucuons and	u the latest line	ormation.			<b>I</b>			
Part I Emp	loyee						Ap	plicable La	rge Employ	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 identificatio	n number (EIN)	
Johnny		E Ison		×	(XX-XX-998	33	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (in	ncluding apartm	nent no.)					9 Street address	(including room	10 Conta	10 Contact telephone number				
264 Loudermi	lk Rd						2055 Cleveland Hwy					7062593344		
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	13 Country and ZIP or foreign postal co		
Chatsworth	(	GA		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):		
	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	S 135.00	\$ 135.00	
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 € (0000	

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

Cat. No. 60705M

## **Instructions for Recipient**

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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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

**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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- 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				on for e	ach ind	ividual	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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#### 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

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

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OMB No. 1545-2251

2023

Internal Revenue Se	rvice			Go to www.i	irs.gov/Form	11095C for ins	tructions and	I the latest info							
Part I Emp	oloyee							App	olicable La	rge Employ	er Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle ir	nitial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	yer			8 Empl	oyer identification	n number (EIN)	
Israel		D J	imenez	Z		XXX-XX-46	97 (	Campbell Pri	inting Com	pany, Inc.			58136699	97	
3 Street address (i	ncluding apartr	nent no.)	)				9	9 Street address (including room or suite no.)					act telephone nui	mber	
404 Oakland	Trail Se							2055 Clevela	and Hwy				7062593344		
4 City or town		5 State	or provinc	e	6 Country	and ZIP or foreig	n postal code 1	1 City or town		12 State or pro	/ince	13 Count	13 Country and ZIP or foreign postal coo		
Cleveland		TN			US 373	S 37323 Dalton				GA		US 30	721		
Part II Employee Offer of Coverage						Employee's	Age on Ja	anuary 1		Plan Start	Month (ente	er 2-digit nu	-digit number): 06		
	All 12 Months Jan Feb Mar				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)	\$	\$	98.89	\$ 98.89	S 98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <b>\$</b>	\$ 135.00	\$ 135.00	\$ 135.00	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
<b>17</b> ZIP Code															

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Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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 (2023)

#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Kathy Kisselburg PO Box 62 Blue Ridge, GA 30513

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

**CORRECTED** 

OMB No. 1545-2251

VOID

2023 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) Kathy Kisselbura XXX-XX-5515 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number PO Box 62 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 Blue Ridge US 30513 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 1E 1H 1H 1H 1H 1H 1H 1H 1H 1H 1H required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2A 2A 2A 2A 2A 2A 2A 2A 2A code, if applicable) 2A 17 ZIP Code

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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	art III Cove If Emp	red Individ loyer provide	uals ed self-insure	d coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name o First name, r	f covered individual	lual(s) t 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	Kathy		sselburg	XXX-XX-5515			X	X							Зері			Dec
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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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**

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 Sei	vice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	d the latest info	ormation.							
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	mployer)			
1 Name of employ	ee (first name, mi	ddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
William	H	l Kregel			XXX-XX-55	95	Campbell Pr	inting Comp	oany, Inc.			5813669	97		
3 Street address (in	ncluding apartme	ent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber		
1211 Peabody	/ Drive						2055 Clevela	and Hwy				70625933	344		
4 City or town	5	State or provin	се	6 Country a	and ZIP or foreigi	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton	G	βA		US 307	20		Dalton		GA		US 30	721			
Part II Emp	loyee Offer	of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ente	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	135.00	135.00	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
<b>17</b> 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																	
	(a) Name of First name, m	covered in 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	) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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 Laster 295 Cobb Rd Chatsworth, GA 30705

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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							Ар	plicable La	rge Emplo	yer Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle	initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	oyer identification	on number (EIN)	
Kenneth			Laster			XXX-XX-960	02	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	ncluding apartr	ment n	o.)					9 Street address (including room or suite no.)					act telephone nu	ımber	
295 Cobb Rd 2055 Cl								2055 Cleveland Hwy 7062593344						344	
4 City or town		5 Stat	te or provinc	ce	6 Country	and ZIP or foreigi	n postal code	<b>11</b> City or town		12 State or pro	13 Count	ry and ZIP or for	eign postal code		
Chatsworth		GA			US 307	05		Dalton GA				US 30	US 30721		
Part II Emp	loyee Off	er of	Covera	ige		Employee's	Age on J	January 1 Plan Start Month (enter 2-digit num					number): 06		
	All 12 Months	3	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)	\$	\$	98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	
<b>16</b> 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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 473 Burgess Rd Se Dalton, GA 30721

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Intern	al Ray	anua 9	Sarvic	2

# 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						Ар	plicable La	arge Employ	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)	
Carol		A Macon		) ×	(XX-XX-818	89	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	ncluding apartn	nent no.)		<u>'</u>	9 Street address (including room or suite no.)						10 Conta	ct telephone nu	mber	
473 Burgess F	Rd Se						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	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal of		
Dalton		GA		US 307	21		Dalton		GA		US 30	US 30721		
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	
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00°	\$ 135.00	
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

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

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	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

Braden N Madden 3415 Misty Meadows Drive Nw Dalton, GA 30721

Form <b>1095-C</b>	
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.

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Part I Emp	loyee						Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer				8 Emp	loyer identifica	ation number (EIN)		
Braden		N Maddei	n		XXX-XX-91	25	Campbell Printing Company, Inc.						581366	997		
3 Street address (in	ncluding apartm	ent no.)		•	9 Street address (including room or suite no.)							act telephone	t telephone number			
3415 Misty Me	eadows Driv	∕e Nw				:	2055 Clevela	and Hwy				7062593344				
4 City or town	5	State or provin	ce	6 Country	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	ovince		13 Cour	foreign postal code			
Dalton		GA		US 307	21	l i	Dalton		GA		US 30	0721				
Part II Emp	loyee Offe	r of Covera	age	E	Employee's	Age on Ja	anuary 1		Plan Star	t Month (ei	nter 2-c	digit nu	mber):	06		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1H	1H	1	Н	1H	1H		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2A	2A	2	2A	2A	2A		
17 ZIP Code														1005 0		

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Cat. No. 60705M

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Pa	rt III Cove If Em	ered Indi ployer pro	<b>viduals</b> vided self-insu	red 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	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Patrick A Mealer 3509 Hurricane Rd Rocky Face, GA 30740

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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.

2023

Internal Revenue Sei	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	d the latest inf									
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)			
Patrick		A Mealer			(XX-XX-66 <sup>7</sup>	79	Campbell Pr	inting Com		5813669	97					
3 Street address (in	ncluding apartm	nent no.)					9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number				
3509 Hurrican	ne Rd						2055 Clevela	and Hwy		7062593344						
4 City or town	5	5 State or province	ce	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 of				
Rocky Face	-	GA		US 307	40		Dalton		GA		US 30	721				
Part II Emp	oloyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	<b>Month</b> (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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- **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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- **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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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	irt III Co	<b>overed I</b> Employer	ndiv prov	<b>riduals</b> rided self-insu	red coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> Nai First na	me of cover me, middle	red 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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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Diana M Mendez 2709 Glendale Dr Gainesville, GA 30507

Form •	10	9	<b>5</b> –	C
Depart	ment	of the	Treas	sury
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. Go to www irs gov/Form1095C for instructions and the latest information

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Service Go to www.irs.gov/Form1095C for inst							nd the latest i	information.							
Part I Emp	ployee						A	Applicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	yee (first name,	middle initial,	last name)	2 Social	security number	(SSN)	7 Name of em	nployer			<b>8</b> Er	mployer identifica	ation number (EIN)		
Diana		M Men	dez		XXX-XX-74	31	Campbell	Printing Con	npany, Inc.			581366	5997		
3 Street address (	including apartr	ment no.)		•			9 Street addre	ess (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
2709 Glendal	e Dr						2055 Clev	eland Hwy				7062593344			
4 City or town		5 State or pro	ovince	6 Country	y and ZIP or foreig	n postal code	11 City or town 12 State or			ovince	<b>13</b> Co	Country and ZIP or foreign postal coo			
Gainesville		GA		US 30	507		Dalton		GA		US	30721			
Part II Emp	ployee Off	er of Cov	erage		Employee's	s Age on .	January 1		Plan Star	t <b>Month</b> (e	nter 2-digit ı	-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	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 98.	89 \$ 98.89	\$ 98.89	<b>)</b> \$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2A	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**

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- 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	Covered Individuals If Employer provided self-insured				on for e	ach 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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#### 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

Anthony Montgomery 784 Mcghee PI Dalton, GA 30721

Form	095	5-C
Departm	ent 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.

2023

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oloyee						Applicable Large Employer Member (Employer)									
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oloyee Offe	r of Covera	ge	E	Employee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (ent	er 2-digit nur	mber):	06			
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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Pa	If Employ	d Individuals ver provided self-insure	ed coverage, check th	e box and enter th	ne information	on for e	each inc	dividual	enrolle	d in cov	/erage,	includir	ng the e	employe	e. X		
	(a) Name of co	overed individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or othe	r (d) Covered					(e	) Months	of covera	ge				
	First name, mid	dle initial, last name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Ser	rvice		Go to www.	irs.gov/Form	1095C for ins	tructions and	d the latest info	rmation.							
Part I Emp	oloyee						App	licable La	arge Emplo	yer Membe	r (Employ	er)			
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of employ	/er			8 Emp	oloyer identification	on number (EIN)		
Beatriz		Morales	s Nunez		XXX-XX-76	27	Campbell Pri	nting Com	pany, Inc.			5813669	97		
3 Street address (i	ncluding apartr	ment no.)		•			9 Street address (	including roon	or suite no.)		10 Contact telephone number				
126 Loma Lar	ne						2055 Clevela	nd Hwy				70625933	344		
4 City or town		5 State or provin	ce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Cour	ntry and ZIP or for	eign postal code		
Dalton		GA		US 307	'20		Dalton		GA		US 3	US 30721			
Part II Emp	oloyee Off	er of Covera	age	, I	Employee's	Age on J	anuary 1		Plan Start	Month (ente	er 2-digit nu	-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)	\$	\$ 98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 135.00\$	3 135.00	\$ 135.00	\$ 135.00	135.00	\$ 135.00	\$ 135.00		
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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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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Intern	al Ray	ani ia (	Sarvio	20

## **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.

vice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	d the latest inf	ormation.							
loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)			
ee (first name, m	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
	Morrell			XXX-XX-130	00	Campbell Printing Company, Inc.					581366997			
ncluding apartme	ent no.)		'			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
Parkway						2055 Clevela	and Hwy				7062593344			
5	State or province	се	6 Country	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		
	GΑ		US 301	45		Dalton		GA		US 30	721			
loyee Offe	r of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	06		
						June	July	Aug	Sept	Oct	Nov	Dec		
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\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00°	\$ 135.00		
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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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).
- 11. Reserved for future use.
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- 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.
- 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. (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 Morrell XXX-XX-1300 Thomas  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ 19 XXX-XX-2255 Tracy Morrell  $\times$  $\times$  $\times$  $\times$ |X||X||X|Garrett Morrell XXX-XX-0827 21 22 23 24 25 26 27 28 29 30

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Amanda Morrison 1303 Stevenson Dr Dalton, GA 30721

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Interna	al Reve	nue Ser	vice

## 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						A	pplicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	vee (first name, i	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	oloyer			8 Emplo	yer identificatio	n number (EIN)		
Amanda		Morris	on		XXX-XX-08	369	Campbell Printing Company, Inc.					581366997			
3 Street address (i	including apartn	nent no.)					9 Street addres	ss (including room	or suite no.)		10 Conta	10 Contact telephone number			
1303 Stevens	on Dr						2055 Cleve	land Hwy				7062593344			
4 City or town		5 State or provi	nce	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Dalton		GA		US 30	721		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	er of Cover	age		Employee <sup>3</sup>	's Age on d	January 1		Plan Start	<b>Month</b> (ent	er 2-digit nur	nber):	06		
	All 12 Months Jan Feb Mar Apr Ma						June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	;	\$	\$	\$	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00\$	\$ 135.00°	\$ 135.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2D	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

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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.

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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-insured				on for e	ach ind	ividual	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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**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 Nelson 1098 Old Grade Rd Resaca, GA 30735

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Form	IU	<i>1</i> 95	<b>-</b> U
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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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Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Fori	<i>m10</i> 95C for in	structions ar	d the latest ir	nformation.								
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)				
1 Name of employ	ee (first name, r	niddle initial, last	name)	2 Socia	I security number	er (SSN)	7 Name of emp	ployer	<b>8</b> Er	nployer identifica	ation number (EIN)					
Timothy	1	K Nelson			XXX-XX-2934			Campbell Printing Company, Inc.					581366997			
3 Street address (i	ncluding apartm	nent no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number				
1098 Old Gra	de Rd						2055 Cleve	eland Hwy				706259	3344			
4 City or town	5	State or provin	ce	6 Countr	y and ZIP or forei	ign postal code	11 City or town		12 State or pr	ovince	<b>13</b> Co	untry and ZIP or	foreign postal code			
Resaca		GA		US 30	735		Dalton		GA		US	30721				
Part II Emp	oloyee Offe	r of Covera	age		<b>Employee</b>	's Age on c	lanuary 1		Plan Star	t 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)		1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ \$		\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A			
17 ZIP Code									No. 60705M				1095-C (2022)			

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Cat. No. 60705M

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Pa	IT III Cove	red Indi	<b>viduals</b> vided self-insu	ured coverage, check th	ne box and enter th	e information	on for e	each 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
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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Clinton Nichols 33 Furrow Lane Chatsworth, GA 30705

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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.

2023

Internal Revenue Se	rvice		Go to www.	ırs.gov/Fori	m1095C for in:	structions an	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, m	niddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Clinton		Nichol	S		XXX-XX-75	521	Campbell Pr	rinting Com		5813669	97				
3 Street address (i	ncluding apartm	ent no.)					9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
33 Furrow Lar	ne						2055 Cleveland 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 pro	vince	13 Countr	13 Country and ZIP or foreign postal code			
Chatsworth		GΑ		US 30	705		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on J	anuary 1		Plan Start	<b>Month</b> (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)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 98.89	9\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00°	\$ 135.00		
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Cat. No. 60705M

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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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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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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 nevertue Ser	vice		ao to www.	is.govii oiiii	70000 101 1113	ti uctions and	a the latest line	ormation.							
Part I Emp	loyee						Applicable Large Employer Member (Employer)								
1 Name of employe	ee (first name,	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Rickey		L Nixon			XXX-XX-47	48	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (in	ncluding apartr	ment no.)					9 Street address	(including room	10 Conta	ict telephone nu	ımber				
PO Box 1061							2055 Cleveland Hwy					7062593344			
4 City or town		5 State or province	се	6 Country a	6 Country and ZIP or foreign postal code			11 City or town		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	loyee Offe	er of Covera	age	E	Employee'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)	\$	\$ 98.89	\$ 98.89\$	S 98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- 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	<b>viduals</b> vided self-insu	ured coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> 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
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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

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 LO WWW.II	s.gov/Form	10950 101 1115	u ucuons and	u tile latest lilli	ormation.						
Part I Emp	loyee						Ар	plicable La	arge Employ	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		>	(XX-XX-38	46	Campbell Pr	inting Com		5813669	97			
3 Street address (in	ncluding apartn	nent no.)					9 Street address	(including room	10 Conta	10 Contact telephone number				
482 Glenn Ho	ward Road						2055 Clevela	and Hwy		7062593344				
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 Count	13 Country and ZIP or foreign postal code		
Chatsworth		GA		US 307	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	<b>Month</b> (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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	<b>\$</b> 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	
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													00E C (2000)	

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. 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.

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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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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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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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- **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.

Pa	I <b>rt III</b> Covere			ured coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of (			(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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#### 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

CHRISTOPHER PITTMAN 4177 BROWN BRIDGE RD 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 Se	rvice		Go to www	.irs.gov/For	<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	ee (first name, m	niddle initial, las	t name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			<b>8</b> En	nployer identifica	tion number (EIN)			
CHRISTOPHE	ER	PITTM	IAN		XXX-XX-70	014	Campbell F	Printing Com	npany, Inc.			581366	997			
3 Street address (i	ncluding apartm	ent no.)					9 Street addre	ss (including roo	n or suite no.)		<b>10</b> Co	10 Contact telephone number				
4177 BROWN	I BRIDGE F	RD					2055 Cleve	eland Hwy				706259	3344			
4 City or town	5	State or provin	nce	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Co	13 Country and ZIP or foreign postal co				
DALTON		GΑ		US 30	0721		Dalton		GA		US	US 30721				
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on	January 1		Plan Star	rt 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	2A	2A	2D	2D	2D			
17 ZIP Code													1005 0 2000			

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

Cat. No. 60705M

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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.

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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-insured				on for e	ach 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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**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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# 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 to www.ii	rs.gov/Form	1095C for ins	tructions an	d the latest info	ormation.							
Part I Emp	oloyee						Ap	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Jesse		A Ramire	z		XXX-XX-93	95	Campbell Printing Company, Inc.					5813669	97		
3 Street address (i	ncluding apartm	ent no.)		<u>'</u>			9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
2952 Carol Ci	rcle						2055 Clevela	and Hwy				7062593344			
4 City or town	5	State or provin	ce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code		
Rocky Face		GA		US 307	40		Dalton		GA		US 30	721			
Part II Emp	oloyee Offe	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	: <b>Month</b> (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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	9\$ 135.00	)\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
Astructions)			2C	2C	2C	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code									lo 60705M				<b>005-C</b> (2022)		

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

Cat. No. 60705M

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- 1Y. Reserved for future use.
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Pa		overed I Employer			ed coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	e. 🗵		-
	(a) Nai	me of cove	red in	dividual(s) , last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	1					Months			01	0.1	N	<b>D</b>
	Tirstria	mo, middic	, ii iitidi	, last name		The is not available)	uii 12 montiis	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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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 Se	rvice		Go to www.ir	s.gov/Form	1095C for ins	tructions and	I the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	arge Employ	er Membe	er (Employe	er)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identificatio	n number (EIN)		
Derrick		Rich			XXX-XX-83	25	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (i	ncluding apartm	ent no.)				!	9 Street address	(including room	n or suite no.)		10 Cont	10 Contact telephone number			
1495 Sane Ro	d Se						2055 Cleveland Hwy					7062593344			
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	vince	13 Coun	13 Country and ZIP or foreign postal of			
Dalton		GA		US 307	21		Dalton		GA		US 30	US 30721			
Part II Emp	oloyee Offe	r of Covera	age	E	Employee'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		
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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	2C		
17 ZIP Code													005 0		

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Cat. No. 60705M

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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.
- **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.
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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	ge Aug	Sept	Oct	Nov	Dec
18	Derrick	Rich	XXX-XX-8325	,		X	×	X	X	×	X		X	X	X	×	X
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Page 4

Form 1095-C (2023)

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Jeff L Ridley 2011 Fullers Chapel Road Chatsworth, GA 30705

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Form	U	J	J	U
Depart	tment	of the	e Trea	sury
Interna	al Rev	enue	Servi	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 nevertue Ser	VICE		ac to www.n	s.gov/i oiiii	70000 101 1113	ti uctions and	a tile latest lill	ormation.							
Part I Emp	loyee						Ар	plicable La	arge Emplo	yer Membe	er (Employe	er)			
1 Name of employe	ee (first name,	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	on number (EIN)		
Jeff		L Ridley			XXX-XX-21	80	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (in	ncluding apartr	ment no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number			
2011 Fullers C	Chapel Roa	ad				1:	2055 Cleveland Hwy					7062593344			
4 City or town	•	5 State or province	ce	6 Country	and ZIP or foreig	n postal code 1	11 City or town		12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal of			
Chatsworth		GA		US 307	05	I	Dalton		GA		US 30	US 30721			
Part II Emp	loyee Off	er of Covera	nge	E	Employee's	Age on J	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	<b>\$</b> 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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		D. d. atica	Dat Nicking						lo 60705M				095-C (2023)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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).
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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).
- 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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- **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.
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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	I <b>rt III</b> 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	Jeff	L	Ridley	XXX-XX-2180			X	×	X	X	×	X	X	X	Х	X	X	X
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#### 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

Theresa L Ridley Po Box 602 Chatsworth, GA 30705

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Depar	tme	ent c	of th	e T	reas	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.

RRECTED 2023

Internal Revenue Ser	vice		Go to www.ii	rs.gov/Form	1095C for ins	tructions and	d the latest inf	ormation.								
Part I Emp	loyee						Ар	plicable La	arge Employ	yer Membe	er (Employe	er)				
1 Name of employe	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emp	oyer identificatio	n number (EIN)			
Theresa		Ridley			XXX-XX-60	72	Campbell Pr	rinting Com	pany, Inc.			5813669	97			
3 Street address (in	ncluding apartm	ent no.)		'	9 Street address (including room or suite no.)						10 Cont	10 Contact telephone number				
Po Box 602					2055 Cleveland Hwy							7062593344				
4 City or town	5	State or province	ce	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code			
Chatsworth		GΑ		US 307	05		Dalton		GA		US 30	0721				
Part II Emp	loyee Offe	r of Covera	age		Employee's	Age on J	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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00			
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												- 1	005 (2000)			

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

Cat. No. 60705M

## **Instructions for Recipient**

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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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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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- 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				on for e	ach 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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#### 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

Filemon R Rodriguez 117 Bear Den Ct 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/Form1095C for instruc								u trie latest illi	ormation.						
Part I Emp	oloyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle	e initial, last r	name)	2 Social s	security number (	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	n number (EIN)	
Filemon		R	Rodrigu	ez		XXX-XX-66 <sup>2</sup>	13	Campbell Pr	inting Com	pany, Inc.			5813669	97	
3 Street address (i	ncluding aparti	ment r	10.)		•			9 Street address	(including room	or suite no.)		10 Cont	act telephone nu	ımber	
117 Bear Den	ı Ct							2055 Clevela	and Hwy				7062593344		
4 City or town		5 Sta	te or provinc	е	6 Country	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Coun	try and ZIP or fore	eign postal code	
Dalton		GΑ			US 307	'21		Dalton		GA		US 30	)721		
Part II Emp	oloyee Off	er o	f Covera	ge		Employee's	Age on J	anuary 1		Plan Start	t <b>Month</b> (ent	er 2-digit nu	mber):	06	
	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	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$	98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2H	2H	2H	2H	2H	2H	2H	
<b>17</b> ZIP Code															

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

Cat. No. 60705M

## **Instructions for Recipient**

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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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

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

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Pa	Irt III Coverd	ed Indi oyer pro	<b>viduals</b> vided self-insur	ed coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle	d in cov	/erage,	includir	ng the e	employe	ee. 🗵		
	(a) Name of			(b) SSN or other TIN	(c) DOB (if SSN or other	(d) Covered						) Months						
	First name, m	iddle initia	al, last name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Filemon	R	Rodriguez	XXX-XX-6613			$\times$	$\times$	$\times$	$\times$	$\times$							
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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

Luis C Rubio 290 Springfield Drive Chatsworth, GA 30705

Form	095	5-C
Departm	ent of the	Treasury
Intornal	Davanua C	onvioo

# 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	s.gov/Form	10950 101 1115	u ucuons and	u tile latest lilli	ormation.			I .				
Part I Emp	oloyee						Ар	plicable La	arge Employ	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)		
Luis		C Rubio		>	(XX-XX-84!	57	Campbell Pr	inting Com		5813669	97				
3 Street address (in	ncluding apartn	nent no.)		<u> </u>			9 Street address	(including room	10 Conta	Contact telephone number					
290 Springfiel	d Drive						2055 Cleveland Hwy					7062593344			
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	13 Country and ZIP or foreign postal co-			
Chatsworth		GA		US 307	05		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		
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\{</i>	\$ 135.00		
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 (2000)		

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Cat. No. 60705M

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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

Olga Rubio 3799 Tibbs Bridge Dalton, GA 30721

Form	10	95-	-C
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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

2023

Internal Revenue Se	ervice		Go to www.	irs.gov/For	m1095C for ins	structions ar	nd the latest in	ormation.								
Part I Em	ployee						Ap	plicable La	arge Emplo	yer Membe	r (Employ	er)				
1 Name of employ	yee (first name,	middle initial, las	t name)	2 Socia	al security number	(SSN)	7 Name of empl	oyer			8 Emp	oloyer identificatio	n number (EIN)			
Olga		Rubio			XXX-XX-6307 Campbell Printing Company, Inc.							581366997				
3 Street address (	including aparti	ment no.)		'			9 Street address	s (including roon	n or suite no.)		<b>10</b> Con	10 Contact telephone number				
3799 Tibbs B	ridge						2055 Clevel	and Hwy				70625933	344			
4 City or town		5 State or provin	nce	6 Count	y and ZIP or foreign postal code 11 City or town 12 State or province				13 Cou	13 Country and ZIP or foreign postal code						
Dalton		GA		US 30	)721		Dalton GA					US 30721				
Part II Em	ployee Off	er of Cover	age		Employee's	s Age on c	January 1		Plan Start	Month (ent	er 2-digit nı	-digit number):				
	All 12 Months Jan Feb Mar					May	June	July	Aug	Sept	Oct	Nov	Dec			
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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).
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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.
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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.
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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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

BRADLEY SHERWOOD 2527 MADDOX CHAPEL RD 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.	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	/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)		
BRADLEY		SHER	WOOD		XXX-XX-0	362	Campbell F	Printing Com		58136	5997				
3 Street address (in	ncluding apartme	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
2527 MADDO	X CHAPEL	RD					2055 Cleve	eland Hwy		7062593344					
4 City or town 5 State or province 6 Country and ZIP or foreign post							11 City or town 12 State or province 13 (					intry and ZIP or	foreign postal code		
DALTON GA US 30721							Dalton		GA		US 3	30721			
Part II Emp	loyee Offe	r of Cover	age		Employee	s Age on c	lanuary 1		Plan Star	rt Month (ei	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	2A	2D	2D		
17 ZIP Code			Act Notice and						N- 00705M				. 1005 C (2000)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach 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 (2023)

#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Roger Sistrunk 1710 Westside 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.

CORRECTED

VOID

OMB No. 1545-2251

Internal Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.															
Part I Emp	oloyee						App	yer)							
1 Name of employ	vee (first name,	middle initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	yer			8 Er	8 Employer identification number (EIN)			
Roger		Sistrun	k		XXX-XX-20	35	Campbell Printing Company, Inc.					581366997			
3 Street address (including apartment no.)							9 Street address	(including roon	n or suite no.)		<b>10</b> Cd	ntact telephone	number		
1710 Westside Circle							2055 Clevela	ind Hwy				706259	3344		
4 City or town 5 State or province 6 Country an						n postal code	11 City or town	<b>.</b>	12 State or pro	vince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Rocky Face GA US 30740							Dalton		GA		US	30721			
Part II Emp	er of Covera	Age on J						ligit 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	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2A	2A	2A	2A	2A		
17 ZIP Code															

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	rt III Coverd If Emplo		ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(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	ge Aug	Sept	Oct	Nov	Dec
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#### 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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## **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.

2023 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) Christopher М Smith XXX-XX-8858 Campbell Printing Company, Inc. 581366997 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1910 Tibbs Terrace 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 GA US 30720 Dalton GA US 30721 Dalton **Employee Offer of Coverage** Part II **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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 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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Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

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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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- 1W. Reserved for future use.
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	(a) Name of c First name, mid			(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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Kenneth L Smith 1018 Somerset Place Cohutta, GA 30710

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CORRECTED

VOID

OMB No. 1545-2251

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2023

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						Ар	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 identificatio	n number (EIN)
Kenneth	L	Smith			XXX-XX-63!	56	Campbell Pr	inting Comp		581366997			
3 Street address (in		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 State or province 6 Country and ZIP or foreign postal of							11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code
Cohutta GA US 30710							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 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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00\$	S 135.00	\$ 135.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H
<b>17</b> ZIP Code													205.0

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach 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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Danny L Sosebee 5004 Muse Rd Sw Resaca, GA 30735

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CORRECTED

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OMB No. 1545-2251

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2023

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Part I Emp	oloyee						Ар	plicable La	arge 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)		
Danny		L Sosebe	ee		(XX-XX-656	50	Campbell Pr	inting Com		581366997					
3 Street address (in	ncluding 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 province	ce	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		
Resaca		Dalton		GA		US 30	721								
Part II Emp	oloyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	<b>Month</b> (ent	er 2-digit nur	2-digit number): 06			
	All 12 Months Jan Feb Mar Apr May							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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- **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.
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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			ed 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	Sept Oct Nov Dec			
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#### 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 C Sutton 2817 Cleveland Hwy Dalton, GA 30721

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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.

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Internal Revenue Sei	vice		Go to www.i	rs.gov/Form	1095C for ins	tructions and	s and the latest information.										
Part I Emp	loyee						Ар	plicable La	rge Employ	er Membe	er (Employe	er)					
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN) 7	7 Name of emplo	oyer			8 Emplo	oyer identificatio	n number (EIN)				
William		C Sutton			XXX-XX-69	40 (	Campbell Pr	inting Com		581366997							
3 Street address (in	ncluding apartm	ent no.)				9	Street address	(including room	10 Conta	10 Contact telephone number							
2817 Clevelar	nd Hwy					2	2055 Clevela	and Hwy				7062593344					
4 City or town	5	State or provin	се	6 Country	and ZIP or foreigi	n postal code 1	1 City or town		12 State or prov	vince	13 Count	ry and ZIP or fore	eign postal code				
Dalton		GA		US 307	21	[	Dalton		GA		US 30	721					
Part II Emp	loyee Offe	r of Covera	age		Employee's	Age on Ja	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)		1E	1E	1E	1E	1E	1E 1E		1E	1E	1E	1E	1E				
15 Employee Required Contribution (see instructions)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	98.89 \$ 135.00 \$ 135.00			135.00	\$ 135.00	\$ 135.00	\$ 135.00				
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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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).
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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.

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 Aug Jan Feb Mar Apr May June July Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ С Sutton XXX-XX-6940 18 William 19 20 21 22 23 24 25 26 27 28 29 30

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

OMB No. 1545-2251

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

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						Ap	plicable La	arge Emplo	yer Membe	er (Employe	r)			
ee (first name,	middle initial, las	t name)	2 Social	security numbe	r (SSN)	7 Name of emplo	oyer			8 Emplo	8 Employer identification number (EIN)			
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ncluding apart	ment no.)		<u>'</u>			9 Street address	(including room	n or suite no.)		10 Conta	10 Contact telephone number			
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

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- 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-insured				on for e	ach ind	ividual	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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#### 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

Erendira Vazquez 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	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	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	oyer identification	n number (EIN)		
Erendira		Vazque	ez		XXX-XX-08	25	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	act telephone nu	ımber		
200 Hewitt Road							2055 Clevela	and Hwy				70625933	344		
4 City or town		5 State or province	ce	6 Country	and ZIP or foreigi	n postal code 1	1 City or town		12 State or pro	vince	13 Count	ry and ZIP or for	eign postal code		
Dalton		GA		US 307	21	1	Dalton		GA		US 30	US 30721			
Part II Emp	loyee Off	er of Covera	age		Employee's Age on January 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)	\$	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00		
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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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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- **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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- 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-insured				on for e	ach 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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#### 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

Isela Vazquez Fraire 200 Hewitt 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.

VOID

OMB No. 1545-2251

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Part I Emp	loyee						Ap	plicable La	rge Emplo	r (Employe	(Employer)				
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	on number (EIN)		
Isela		Vazque	ez Fraire		XXX-XX-38	76	Campbell Pr	inting Com	pany, Inc.			5813669	97		
3 Street address (in	ncluding apartm	nent no.)		•			9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber		
200 Hewitt Dri	ive						2055 Clevela	and Hwy				70625933	344		
4 City or town		5 State or provin	ce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal coo			
Dalton		GA		US 307	21		Dalton		GA		US 30	721			
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	-digit number):			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug			Nov	Dec		
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17 ZIP Code															

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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-insured				on for e	ach 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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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Sarahi Velasquez Villegas 1119 Ridgeleigh Circle 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.

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ding apartme	Velasqu ent no.)	,		•	` '	•	yer			8 Emplo	ver identificatio	n number (EIN)	
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	State or province		9 Street address (including room or suite no.)					or suite no.)		10 Conta	ct telephone nu	ımber	
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	\$ 98.89	\$ 98.89\$	98.89	\$ 98.89	\$ 98.89	9\$ 135.00	\$ 135.00	\$ 135.00	\$ 135.00 <i>\$</i>	\$ 135.00 <i>\$</i>	\$ 135.00	\$ 135.00	
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Cat. No. 60705M

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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
- **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.
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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-insured				on for e	ach 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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#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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

Matthew Watts Po Box 505 Resaca, GA 30735

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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.

2023 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) Matthew Watts XXX-XX-5308 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 505 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 Resaca GA US 30735 Dalton GA US 30721 **Employee Offer of Coverage** Part II 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 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E 1E required code) 15 Employee Required Contribution (see 98.89\$ 98.89\$ 98.89 \$ 98.89 \$ 98.89\$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 \$ 135.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C 2C code, if applicable) 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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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- **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.
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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 <b>rt III Cover</b> If Empl	<b>ed Individua</b> oyer provided	als self-insured	d coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵	,]	
	(a) Name of First name, m	covered individua iddle initial, last n	al(s) ame	(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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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Briley Whitener 295 Cobb 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.

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Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	ee (first name, i	middle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Briley		White	ner		XXX-XX-1	707	Campbell Printing Company, Inc.					581366997			
3 Street address (in	ncluding apartn	nent no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
295 Cobb Rd							2055 Cleve	eland Hwy				706259	3344		
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	<b>13</b> Cou	13 Country and ZIP or foreign postal co			
Chatsworth		GA		US 30	US 30705				GA		US 3	US 30721			
Part II Employee Offer of Coverage Employee's Ag							January 1		Plan Sta	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)	\$	\$	\$	5	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	2A	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**

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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				on for e	ach ind	ividual	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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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Tracy L Willin 2952 Carol Circle Rocky Face, GA 30740

OMB No. 1545-2251

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

VOID

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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2952 Carol Circle						2055 Clevela	and Hwy				7062593344			
4 City or town 5 State or province				and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Rocky Face GA						Dalton		GA		US 30	721			
Part II Employee Offer of Coverage					Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	06		
					May	June	July	Aug	Sept	Oct	Nov	Dec		
	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
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												<b>095-C</b> (2023)		
	ee (first name, recluding apartment)  Including apartment apartment)  Including apartment apartm	ee (first name, middle initial, last L Willin Including apartment no.)  TCIE  5 State or proving GA  Ployee Offer of Covera  All 12 Months Jan  1E  \$ 98.89	L   Willin	Social s   2    2    2    3    3    3    3	Social security number	See (first name, middle initial, last name)   2   Social security number (SSN)   XXX-XX-8119	App   Social security number (SSN)   7 Name of employer (SSN)   2 Social security number (SSN)   7 Name of employer (SSN)   2 Social security number (SSN)   7 Name of employer (SSN)   2 Social security number (SSN)   7 Name of employer (SSN)   11 City or town Dalton   11 City or town Dalton   12 Name of employer (SSN)   13 City or town Dalton   14 City or town Dalton   15 Name of employer (SSN)   15 Name of employer (SSN)   16 Name of employer (SSN)   16 Name of employer (SSN)   16 Name of employer (SSN)   17 City or town Dalton   16 Name of employer (SSN)   18 Name	Applicable Labe   Applicable   Applicable   Labe   Applicable   Labe   Applicable   App	Applicable Large Employer   Social security number (SSN)   7 Name of employer   Campbell Printing Company, Inc.   Name of employer   Campbell Printing Company, Inc.   Social security number (SSN)   XXX-XX-8119   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Campbell Printing Company, Inc.   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   To Ame of employer   Campbell Printing Company, Inc.   Social security number (SSN)   Social security numb	Applicable Large Employer Member   Security number (SSN)   7 Name of employer   Campbell Printing Company, Inc.   Street address (including room or suite no.)   Str	Applicable Large Employer Member (Employer Bergins to provide   Campbell Printing Company, Inc.   State or province   GA	Applicable Large Employer Member (Employer)		

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. 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 you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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-insured				on for e	ach ind	ividual	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 (2023)

#### 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. For more information about the employer shared responsibility provisions, visit IRS.gov.

**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