Colton Evan Amis 316 WESTCHESTER AVENUE SW HUNTSVILLE, AL 35801

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Intern	al Ray	anua Sar	vice

Colton

4 City or town

HUNTSVILLE

Part I Employee

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

3 Street address (including apartment no.)

316 WESTCHESTER AVENUE SW

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AL

Amis

5 State or province

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

2 Social security number (SSN)

US 35801

XXX-XX-1273

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

2023 Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (EIN) Apartment Hunters, Inc. 631031253 9 Street address (including room or suite no.) 10 Contact telephone number 8841 Helena Road 2055885843 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Pelham AL US 35124

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art II Employee Offer of Coverage					s Age on J	anuary 1		Plan Star	09				
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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	loyee Offe	All 12 Months Jan	All 12 Months Jan Feb	All 12 Months Jan Feb Mar	All 12 Months Jan Feb Mar Apr	All 12 Months Jan Feb Mar Apr May	All 12 Months Jan Feb Mar Apr May June	All 12 Months Jan Feb Mar Apr May June July	All 12 Months Jan Feb Mar Apr May June July Aug	All 12 Months Jan Feb Mar Apr May June July Aug Sept	loyee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit n All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct	All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov	

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

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

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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

CASEY STEVEN BALDWIN 1808 BELAY WAY LOUISVILLE, KY 40245

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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Internal Revenue Se	ervice		GO TO WW	w.irs.gov/For	m 1095C for in	structions a	na the latest ir	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emp	oloyer)			
1 Name of employ	/ee (first name, n	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8	Employer identific	ation number (EIN)		
CASEY	:	S BALD	WIN		XXX-XX-20)44	Apartment	Hunters, In	C.			63103°	1253		
3 Street address (i	including apartm	ent no.)		•			9 Street addres	ss (including roc	om or suite no.)		10	10 Contact telephone number			
1808 BELAY	WAY						8841 Heler	na Road				205588	5843		
4 City or town 5 State or province 6 Country and ZIP or foreign p						gn postal code	11 City or town 12 State or province					Country and ZIP or	foreign postal code		
LOUISVILLE KY US 40245							Pelham		AL		U	IS 35124			
Part II Emp	oloyee Offe	r of Cover	rage	Employee'	s Age on	January 1		Plan Sta	rt Month (er	nter 2-dig	git number):	09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	t Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	. 1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005.0		

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Cat. No. 60705M

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ANGELA C BENNETT 2073 CAHABA CREST DRIVE HOOVER, AL 35242

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.					
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, i	middle initial, la	ıst name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identifica	ation number (EIN)
ANGELA		C BENN	IETT		XXX-XX-5	398	Apartment	Hunters, In	C.			631031	253
3 Street address (i	ncluding apartn	nent no.)					9 Street addre	ss (including roo	10 Co	10 Contact telephone number			
2073 CAHABA	A CREST [DRIVE					8841 Helei	na Road				205588	5843
4 City or town	,	5 State or prov	rince	6 Count	ry and ZIP or fore	gn postal code	11 City or town 12 State or province 1				13 Co	untry and ZIP or	foreign postal code
HOOVER		AL		US 35	5242		Pelham AL U					35124	
Part II Emp	loyee Offe	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	09
	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)											2A	2A	2A
17 ZIP Code									No. 60705M				1095-C (2023)

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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

ANDREA N BENTON-WHITE 165 STONECREEK PL CALERA, AL 35040

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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

epartment of the Treasury erral Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.

20**23**

Part I Employ 1 Name of employ	oloyee														
1 Name of employ							A	pplicable L	arge Emplo	yer Memb	er (Employ	/er)			
	/ee (first name,	middle initial,	last name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	ation number (EIN)		
ANDREA		N BEN	ITON-WHITE		XXX-XX-56	-XX-5663 Apartment Hunters, Inc.						631031	253		
3 Street address (including apartr	ment no.)					9 Street addres	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
165 STONEC	REEK PL						8841 Helen	na Road				2055885843			
4 City or town		5 State or pr	ovince	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province					intry and ZIP or	foreign postal code		
CALERA		AL		US 35	040		Pelham AL					US 35124			
Part II Emp	er of Cov	erage	s Age on .	January 1		Plan Star	t Month (er	nter 2-digit n	umber):	09					
-	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter 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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- **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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- 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.																
	(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

JENNIFER BOWLER 455 SPRING RIDGE DR ROSWELL, GA 30076

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.

Internal Revenue Ser	rvice		Go to www	irs.gov/For	m1095C for in	structions an	id 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,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)
JENNIFER		BOWI	_ER		XXX-XX-4	765	Apartment	Hunters, Inc	3 .			63103	1253
3 Street address (i	ncluding apartr	ment no.)					9 Street addre	ess (including roo	10 Co	10 Contact telephone number			
455 SPRING	RIDGE DR	?					8841 Helei	na Road				205588	5843
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	gn postal code	11 City or town 12 State or province 13					untry and ZIP or	foreign postal code
ROSWELL		GA		US 30	0076		Pelham		US	35124			
Part II Emp	loyee Off	er of Cove	rage		Employee	's Age on J	January 1		Plan Star	rt Month (e	nter 2-digit	number):	09
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code									No. 60705M				1095-C (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.

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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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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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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

Byran Brower 2601 ELTON ROAD NW HUNTSVILLE, AL 35810

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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						Α	Applicable L	arge Emplo	yer Memb	er (Emplo	/er)		
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Em	ployer identifica	ation number (EIN)	
Byran		Browe	r		XXX-XX-68	370	Apartment	Hunters, Inc	C.			631031	253	
3 Street address (i	including apartr	ment no.)					9 Street addre	ess (including roo	m or suite no.)		10 Co	ntact telephone	number	
2601 ELTON	ROAD NW	/					8841 Hele	na Road				205588	5843	
4 City or town		5 State or provi	nce	6 Countr	ry and ZIP or foreig	n postal code	11 City or town	1	12 State or pro	12 State or province			foreign postal code	
HUNTSVILLE	-	AL		US 35	810		Pelham AL				US 35124			
Part II Emp	oloyee Offe	er of Cover	age		Employee's	s Age on	January 1		Plan Star	t Month (e	nter 2-digit r	digit number): 09		
	All 12 Months Jan Feb				Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1A	1A	1A	1A	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)		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

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

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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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	(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

ALEX BROWN 3572 HAVEN STREET CINCINNATI, OH 45220

OMB No. 1545-2251

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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.

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2023

Internal Revenue Service

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) **ALEX BROWN** XXX-XX-6356 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 3572 HAVEN STREET 8841 Helena Road 2055885843 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 OH Pelham **CINCINNATI** US 45220 ΑI US 35124 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 Part II All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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Jared A Brown 3100 HEATHERBROOKE RD BIRMINGHAM, AL 35242

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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

Internal Revenue Ser	vice		Go to www.irs.gov/Form1095C for instructions and the latest information.												
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Em	ployer)			
1 Name of employe	ee (first name, m	niddle initial, las	t name)	2 Socia	I security numbe	er (SSN)	7 Name of em	ployer				8 Employer ider	ntification r	number (EIN)	
Jared		A Brown			XXX-XX-30	064	Apartment Hunters, Inc.					631031253			
3 Street address (in	ncluding apartme	ent no.)		•			9 Street addre	9 Street address (including room or suite no.) 10				10 Contact telephone number			
3100 HEATHE	ERBROOKE	E RD					8841 Helei	na Road				205	5885843	3	
4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12						12 State or p	rovince	1	3 Country and ZI	P or foreigr	n postal code				
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Part II Emp	loyee Offe	r of Cover	age	•	Employee ³	's Age on	January 1		Plan Star	rt Month (er	nter 2-di	git number):	(09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	et No	v	Dec	
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	(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

TERRI BROWN 7250 ALABAMA HWY 155 MONTEVALLO, AL 35115

Form 1095- C
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.

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Ser	rvice		Go to www.irs.gov/Form1095C for instructions and the latest information.									4		
Part I Emp	loyee						Α	oplicable L	er (Employ	rer)				
1 Name of employ	ee (first name, ı	middle initial, las	t name)	2 Social	security number	(SSN)	7 Name of emp	oloyer			8 Em	Employer identification number (EIN		
TERRI		BROW	/N		XXX-XX-21	27	Apartment	Hunters, In	C.			631031253		
3 Street address (in	ncluding apartn	ment no.)					9 Street address (including room or suite no.) 10 C					Contact telephone number		
7250 ALABAN	/IA HWY 1	55					8841 Helena Road					2055885843		
4 City or town		5 State or proving	nce	6 Country	y and ZIP or foreig	n postal code	11 City or town 12 State or province 13 C					ntry and ZIP or	foreign postal code	
MONTEVALLO AL US 35115							Pelham		AL		US 3	US 35124		
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (enter 2			ter 2-digit n	2-digit number): 09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter 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.



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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Earnest Eucum Bruner 12821 STRATFORD DR APT 124 OKLAHOMA CITY, OK 73120

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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 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) Earnest Ε Bruner XXX-XX-5564 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 12821 STRATFORD DR APT 124 8841 Helena Road 2055885843 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 **OKLAHOMA CITY** Pelham OK US 73120 ΑI US 35124 Part II Employee Offer of Coverage **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan May June July Sept Nov 14 Offer of Coverage (enter 1A 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 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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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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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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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

MATHEW E BUSH 2009 FAIRBANK CIRCLE CHELSEA, AL 35043

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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

RRECTED 201

nent of the Treasury
Revenue Service

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial,	last name)	2 Soc	cial security num	ber (SSN)	7 Name of em	ployer			8 En	nployer identific	cation number (EIN)	
MATHEW		E BUS	SH		XXX-XX-	2509	Apartment	Hunters, In	C.			63103	1253	
3 Street address (in	ncluding aparti	ment no.)		•			9 Street addre	ess (including roc	m or suite no.)		10 Cc	ontact telephon	e number	
2009 FAIRBA	NK CIRCL	.E					8841 Helei	na Road	2055885843					
4 City or town		5 State or pr	ovince	6 Cou	ntry and ZIP or fo	reign postal code	de 11 City or town 12 State or province 13 Country					3 Country and ZIP or foreign postal code		
CHELSEA		AL		US 3	35043		Pelham		AL					
	loyee Off	er of Cov	erage		Employe	e's Age on c	January 1		Plan Sta	rt Month (er	nter 2-digit r	number):	09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														
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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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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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- **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.

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

Alexia E Cain 11643 GREENE STREET SODDY DAISY, TN 37379

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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.	irs.gov/Fo	<i>m10</i> 95C for in	nstructions ar	nd the latest in	nformation.								
Part I Emp	ployee							Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)				
1 Name of employ	yee (first name,	middle ini	itial, last na	me)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 Er	nployer identifica	ation number (EIN)			
Alexia		E C	ain			XXX-XX-4	358	Apartment	Hunters, In		631031253						
3 Street address (including apartr	ment no.)			•			9 Street addre	ss (including roc	m or suite no.)		10 Co	10 Contact telephone number				
11643 GREE	NE STREE	T						8841 Helei	na Road				205588	5843			
4 City or town		5 State o	r province		6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or pr	rovince	13 Co	ountry and ZIP or	foreign postal code			
SODDY DAIS	SY	TN			US 37	7379		Pelham		AL		US	35124				
Part II Emp	Part II Employee Offer of Coverage Employee's Ag							January 1		Plan Star	rt Month (er	nter 2-digit					
	All 12 Months	Ja	an	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1.	A	1A	1A	1A	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			
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.

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.

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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).
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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).
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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 A COOK 3916 LUCERNE DRIVE MEMPHIS, TN 38115

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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

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) **MARIA** СООК XXX-XX-9568 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 3916 LUCERNE DRIVE 8841 Helena Road 2055885843 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 **MEMPHIS** US 38115 Pelham ΤN ΑI US 35124 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 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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- 1X. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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

NOE IBARRA DEGANTE 325 BRADFORD FARMS DRIVE MADISON, AL 35758

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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	ervice		Go to www	Go to www.irs.gov/Form1095C for instructions and the latest information.								2020				
Part I Emp	ployee						Α	pplicable l	arge Empl	oyer Memb	er (Emplo	yer)				
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer 8					8 Employer identification number (EIN				
NOE		I DEGA	ANTE		XXX-XX-17	796	Apartment Hunters, Inc.					631031253				
3 Street address (i	including apartm	nent no.)		<u>'</u>			9 Street addre	ess (including roo	om or suite no.)		10 C	10 Contact telephone number				
325 BRADFORD FARMS DRIVE							8841 Helei	na Road				205588	5843			
4 City or town 5 State or province 6 Country and ZIP or foreign postal co							11 City or town	I	12 State or p	province	13 Co	ountry and ZIP or f	oreign postal code			
MADISON		AL		US 35	5758		Pelham		AL		US	US 35124				
Part II Emp	ployee Offe	er of Cove	rage	·	Employee'	s Age on	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter 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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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.



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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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- 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.																
	(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

LAUREN A DRALAND 1815 GARDNER LANE J77 LOUISVILLE, KY 40205

Form	095-	-C
	ent of the Tre	

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

VOID

OMB No. 1545-2251

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

Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Em	nployer	·)		
1 Name of employ	/ee (first name,	middle initial, la:	st name)	2 Socia	al security number	r (SSN)	7 Name of em	ployer				8 Employ	er identifica	tion number (EIN)	
LAUREN		A DRAL	AND		XXX-XX-80	062	Apartment	Hunters, Ind	.			631031253			
3 Street address (i	including apartr	ment no.)					9 Street addre	ess (including roo	m or suite no.)			10 Contact telephone number			
1815 GARDN	IER LANE .	J77					8841 Helei	na Road					205588	5843	
4 City or town 5 State or province 6 Country and ZIP or foreign postal coordinates to the country and ZIP or foreign postal country and ZI							11 City or town		12 State or pr	ovince		13 Country	and ZIP or f	oreign postal code	
LOUISVILLE		KY		US 40)205		Pelham		AL			US 351	24		
Part II Emp	oloyee Off	er of Cove	rage		Employee'	s Age on .	January 1		Plan Star	t Month (er	nter 2-d	ligit num	ıber):	09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	ct	Nov	Dec	
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	(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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Jessica Paige Early 2909 HIGHLAND AVE 1010 BIRMINGHAM, AL 35205

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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 LO WWW.	irs.gov/ror	11110950 101 111	istructions ar	iu trie iatest ii	mormation.				`			
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Memb	er (Emplo	yer)			
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 Er	8 Employer identification number (EIN			
Jessica		P Early			XXX-XX-9	105	Apartment	Hunters, Inc		631031253					
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 C	10 Contact telephone number			
2909 HIGHLA	2909 HIGHLAND AVE 1010											2055885843			
4 City or town 5 State or province 6 Country and ZIP or foreign postal co							11 City or town		12 State or	province	13 Cd	ountry and ZIP or	foreign postal code		
BIRMINGHAM AL US 35205							Pelham		AL		US	US 35124			
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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.

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

Fain Elbert Edwards JR 490 CHARNELL DRIVE ASHVILLE, AL 35953

Form 1095-C
Department of the Treasury
Internal Revenue Service

17 ZIP Code

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) Ε Edwards XXX-XX-2397 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 490 CHARNELL DRIVE 8841 Helena Road 2055885843 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 ΑL Pelham **ASHVILLE** US 35953 ΑI US 35124 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 Part II All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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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- **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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Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

LISA ELLIS 105 SOUTH RUN CIRCLE HOOVER, AL 35244

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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

Department of the Treasury
Internal Revenue Service

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

2023

internal Revenue Ser	vice		GO LO WWI	w.irs.gov/ror	11110936 101 11	iu trie latest ili	iorination.				_ ~						
Part I Emp	loyee						Applicable Large Employer Member (Employer)										
1 Name of employe	ee (first name,	middle initial, la	st name)	2 Socia	I security numb	er (SSN)	7 Name of emp	loyer			8 Em	ployer identificat	tion number (EIN)				
LISA		ELLIS	5		XXX-XX-2	672	Apartment	Hunters, In		631031253							
3 Street address (in	ncluding apartr	ment no.)					9 Street address	s (including roo	m or suite no.)		10 Cor	10 Contact telephone number					
105 SOUTH R	105 SOUTH RUN CIRCLE							a Road		2055885843							
4 City or town 5 State or province 6 Country and					y and ZIP or fore	eign postal code	11 City or town		12 State or pr	ovince	13 Cou	ntry and ZIP or fo	oreign postal code				
HOOVER AL US 35244							Pelham		AL		US 3	5124					
Part II Emp	loyee Offe	er of Cove	rage	,	Employee	's Age on J	January 1		Plan Star	t Month (en	ter 2-digit n	?-digit number): 09					
All 12 Months Jan Feb Mar Apr						May	June	July	Aug	Sept	Oct	Nov	Dec				
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A				
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																	
17 ZIP Code																	
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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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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

MICHAEL FRENCH 1803 HAWK HILL RD LAGRANGE, KY 40031

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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

Department of the Treasury
Internal Revenue Service

Do not attack
Go to www.irs.gov/Fo

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

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Part I Em	ployee						Δ	Applicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	yee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	nployer			8 Em	ployer identific	ation number (EIN)		
MICHAEL		FRE	NCH		XXX-XX-2	739	Apartment	Hunters, In	C.			63103	1253		
3 Street address (including aparti	ment no.)					9 Street addre	ess (including roc	om or suite no.)		10 Co	10 Contact telephone number			
1803 HAWK I	HILL RD						8841 Hele	na Road				2055885843			
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign po							1	12 State or p	province	13 Cou	13 Country and ZIP or foreign postal code			
LAGRANGE		KY		US 40	0031		Pelham AL				US 3	US 35124			
Part II Em	ployee Off	er of Cove	rage	·	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	09		
All 12 Months Jan Feb Mar						May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	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		
17 ZIP Code															

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

Cat. No. 60705M

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



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

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

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

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

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

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

Joanna Gurley 104 PINEBLUFF TRAIL TRUSSVILLE, AL 35173

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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	ervice		Go to w	ww.irs.gov/F	orm1095C for in	structions a	nd the latest i	nformation.							
Part I Em	ployee						A	Applicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	yee (first name,	middle initial	last name)	2 So	cial security numbe	r (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Joanna		Gur	ley		XXX-XX-97	761	Apartment	Hunters, In	C.			63103	1253		
3 Street address ((including apartr	ment no.)		•			9 Street addre	ess (including roo	m or suite no.)		10 C	10 Contact telephone number			
104 PINEBLU	JFF TRAIL						8841 Hele	na Road				2055885843			
4 City or town		5 State or p	ovince	6 Cou	ntry and ZIP or forei	gn postal code	11 City or town	1	12 State or pro	ovince	13 Cd	13 Country and ZIP or foreign postal co-			
TRUSSVILLE	Ξ	AL		US :	35173		Pelham		AL	US	35124				
Part II Employee Offer of Coverage Employee's Age of							January 1 Plan Start Month (ent				nter 2-digit	er 2-digit number): 09			
	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	1A	1A	1A		
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					
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.

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	(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

Jonathan Steven Harris 510 BELL ST MCMINNVILLE, TN 37110

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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 LO WV	w.irs.gov/ro	111110950 101	instructions at	ons and the latest information.								
Part I Emp	ployee						Α	pplicable L	arge Empl	oyer Memb	er (Empl	oyer)			
1 Name of employ	ee (first name,	middle initial,	last name)	2 Soci	al security num	ber (SSN)	7 Name of emp	ployer			8 E	mployer iden	tification number (EIN)		
Jonathan		S Harr	is		XXX-XX-	9772	Apartment	Hunters, In	C.			6310	031253		
3 Street address (i	including apartı	ment no.)		•			9 Street addre	ss (including roc	10 C	10 Contact telephone number					
510 BELL ST							8841 Heler	na Road				2055885843			
4 City or town		5 State or pro	ovince	6 Coun	try and ZIP or fo	reign postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
MCMINNVILLE TN US 37110							Pelham		AL		US	35124			
Part II Emp	erage	e's Age on	January 1		Plan Star	rt Month (er	nter 2-digit	2-digit number): 09							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	No	v Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1.4	1A		
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17 ZIP Code															

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Cat. No. 60705M

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	(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

SKYLAR HENLEY 7255 Lee Highway Apt 910 CHATTANOOGA, TN 37421

Form 1095-C
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	loyee						Α	pplicable L	arge Emplo	yer Memb	er (Emp	loyer)			
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	I security numbe	er (SSN)	7 Name of em	ployer			8	Employer identifica	tion number (EIN)		
SKYLAR		HENL	EY		XXX-XX-82	260	Apartment	Hunters, Inc	C.			631031253			
3 Street address (i	ncluding apartr	ment no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number			
7255 Lee High	nway Apt 9	10					8841 Helena Road					2055885843			
4 City or town		5 State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province				13 (13 Country and ZIP or foreign postal code			
CHATTANOO	CHATTANOOGA TN US 37421					Pelham AL					S 35124				
Part II Employee Offer of Coverage Employee's Age on					's Age on .	January 1		Plan Star	t Month (e	nter 2-digi	t number):	09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	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		
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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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.



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

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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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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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- **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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- 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 covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

BARBARA W HERSKOWITZ 327 TAIT ROAD STOCKBRIDGE, GA 30281

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Depar	tme	nt of	the T	rea	sury

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

nternal Revenue Service		Go to ww	w.irs.gov/Fo	rm1095C for ins	structions ar	nd the latest in								
Part I Employee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employee (first nam	e, middle initial	, last name)	2 Socia	al security number	r (SSN)	7 Name of em	oloyer			8 En	nployer identifica	ation number (EIN		
BARBARA	W HEI	RSKOWITZ		XXX-XX-41	XX-4119 Apartment Hunters, Inc.						631031	253		
3 Street address (including apa	rtment no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number			
327 TAIT ROAD						8841 Heler	na Road				2055885843			
4 City or town	5 State or p	rovince	6 Count	try and ZIP or forei	11 City or town		12 State or pr	ovince	13 Co	13 Country and ZIP or foreign postal cod				
STOCKBRIDGE	GA		US 30	0281	Pelham		AL		US	US 35124				
Part II Employee Offer of Coverage				Employee'	s Age on .	January 1		Plan Star	t Month (er	nter 2-digit r	igit number): 09			
All 12 Mon	ths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
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Cat. No. 60705M

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Alexander Yearley Hooper 1311 CLEERMONT DR HUNTSVILLE, AL 35801

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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.

CORRECTED 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) Hooper Alexander XXX-XX-3103 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1311 CLEERMONT DR 8841 Helena Road 2055885843 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 US 35801 Pelham HUNTSVILLE AL ΑI US 35124 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H 1H 1A 1A 1A 1H 1H 1H 1H 1H 1H 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2D 2A 2A 2A 2A 2A 2A 2A code, if applicable) 17 ZIP Code

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

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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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

CAROL HOOPER 1311 CLEERMONT DRIVE HUNTSVILLE, AL 35801

OMB No. 1545-2251

Form	1	O	9	5	-	C
Depar	tme	nt d	of th	ne T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

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 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) **CAROL** HOOPER XXX-XX-0547 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1311 CLEERMONT DRIVE 8841 Helena Road 2055885843 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 US 35801 Pelham HUNTSVILLE AL ΑI US 35124 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 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)

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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

DONNA R HRAMEC 107 JACQUELINE RD JASPER, AL 35504

1 NOK_r
Form 1095-C
Department of the Treasury
Internal Decrease Complete

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	rvice		Go to ww	ww.irs.gov/Form1095C for instructions and the latest information.												
Part I Emp	oloyee						A	pplicable l	arge Emplo	yer Memb	er (Emplo	yer)				
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Soci	al security numbe	r (SSN)	7 Name of em	oloyer			8 Em	Employer identification number (EIN				
DONNA		R HRAN	1EC		XXX-XX-02	217	Apartment	Hunters, In		631031253						
3 Street address (i		9 Street addre	ss (including roo	om or suite no.)		10 Co	10 Contact telephone number									
107 JACQUE	LINE RD						8841 Helena Road						2055885843			
4 City or town	:	5 State or prov	ince	6 Count	try and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP or	r foreign postal code			
JASPER AL US 35504							Pelham		AL		US :	35124				
Part II Emp	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit r	iumber):									
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter 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 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

JOHN HRAMEC 107 JACQUELINE RD JASPER, AL 35504

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Form 1095-C	
Department of the Treasury	/
Internal Decreases Country	

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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1 Name of employ	ee (first name,	middle	initial, las	t name)		2 Social	security num	nber (S	SN)	7 Name of emp	loyer				8 Empl	loyer identificati	on number (EIN)	
JOHN			HRAM	EC			XXX-XX	-4926	5	Apartment Hunters, Inc. 631031253							253	
3 Street address (including apartı	ment n	o.)							9 Street addres	s (including room		10 Cont	act telephone n	t telephone number			
107 JACQUE	LINE RD									8841 Helen	a Road					2055885	843	
4 City or town		5 Stat	te or provir	nce		6 Country	and ZIP or fo	oreign p	ostal code	11 City or town		12 State or pro	vince		13 Coun	try and ZIP or for	reign postal code	
JASPER		AL				US 355	504			Pelham		AL			US 35124			
Part II Emp	ployee Off	er of	Cover	age	•		Employe	ee's A	Age on J	anuary 1		Plan Star	t Month (en	ter 2-c	ligit nu	mber):	09	
	All 12 Months	;	Jan	Feb		Mar	Apr		May	June	July	Aug	Sept	С	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)			1A	1A		1A	1A		1A	1A	1A	1A	1A	1	IA	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$	\$		\$	\$	\$	\$	\$		\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter 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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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.



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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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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.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

Tizoc Jesus Jaimes JR 130 MISSION CIRCLE ALABASTER, AL 35007

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Intern	al Roy	anua San	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 Serv	rice		GO to www.	rs.gov/ron	11110950 101 111	Structions ar	iu trie latest li	mormation.				_ `					
Part I Empl	loyee						Applicable Large Employer Member (Employer)										
1 Name of employee	e (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer	8 Em	ployer identific	ation number (EIN)						
Tizoc		J Jaime:	S		XXX-XX-0	761	Apartment	Hunters, Ind		631031253							
3 Street address (inc	cluding apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Cor	10 Contact telephone number					
130 MISSION (CIRCLE						8841 Heler	na Road				205588	5843				
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13 Cou	intry and ZIP or	foreign postal code				
ALABASTER		AL		US 35	007		Pelham		AL		US 3	35124					
Part II Empl	loyee Offe	r of Cover	age	·	Employee ³	s Age on c	January 1		Plan Star	rt Month (er	nter 2-digit n	umber):	09				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H				
15 Employee Required Contribution (see instructions)	\$	\$	\$	3	\$	\$	\$	\$	\$	\$	\$	\$	\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A				
17 ZIP Code													1005.0				

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Cat. No. 60705M

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Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

CHERI JENKINS 6256 RAINBOW ROW PELL CITY, AL 35128

Form	1	095-C
		ent of the Treasury

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 Sel	rvice		GO LO WWW	.irs.gov/roi	11110950 101 11	istructions ar	iu trie latest i	mormation.						
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emple	oyer)		
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
CHERI		JENK	INS		XXX-XX-9	147	Apartment	Hunters, In		631031253				
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ess (including roc	m or suite no.)		10 0	Contact telephone	number	
6256 RAINBO	W ROW						8841 Helei	na Road				205588	5843	
4 City or town	5	5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	ı	12 State or	province	13 C	ountry and ZIP or	foreign postal code	
PELL CITY		AL		US 3	5128		Pelham		AL		US	35124		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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17 ZIP Code			Act Notice on						No. 00705M				- 1005 C (2000	

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Cat. No. 60705M

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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.

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

DARRIN C KERBY 7178 ST ALBANS WAY HAMILTON, OH 45011

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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OMB No. 1545-2251

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

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Part I Employee											Applicable Large Employer Member (Employer)														
1 Name of employe	ee (first name,	middle	e initial, last	: name)		2 Social	securi	ty number	(SSN)	7	Name of empl	oye	r						8 Emp	loye	r identificatio	n number	(EIN)		
DARRIN		С	KERBY	<i>(</i>			XXX	-XX-04	-28	Apartment Hunters, Inc.							631031253								
3 Street address (including apartment no.)										9	Street address	s (ind	cluding room	or su	iite no.)				10 Contact telephone number						
7178 ST ALBANS WAY										8	3841 Helena	a R	Road						2055885843						
4 City or town	6 Country and ZIP or foreign postal code				1	11 City or town 12 State or province					13 Coun	itry a	nd ZIP or fore	ign postal	code										
HAMILTON OH Part II Employee Offer of Coverage							US 45011				Pelham			AL					US 35	512	.4				
Part II Emp	loyee Off	f Covera		Emp	loyee's	s Age on	Ja	anuary 1			Pla	an Starl	Moı	1th (en	ter 2	digit nu!	ımb	er):	09						
	Mar		Apr	May		June		July		Aug	S	ept	Oct		Nov		Dec								
14 Offer of Coverage (enter required code)			1A	1A		1A		1A	1A		1A		1A		1A		ΙA		1A		1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$		\$	\$		\$		\$		\$		\$		\$			
16 Section 4980H Safe Harbor and Other Relief (enter 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.
- **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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- **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.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

Silas Robert Kleinau 314 LAFAYETTE POINT CIR CLARKSVILLE, TN 37042

Form 1095-C
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						A	Applicable I	_arge Empl	oyer Mem	ber (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Silas		R Kleina	ıu		XXX-XX-0	495	Apartment	Hunters, In	IC.			631031253			
3 Street address (i	ncluding apart	ment no.)					9 Street addre	ess (including roo	om or suite no.)		10 C	ontact telephone	number		
314 LAFAYE	TE POIN	T CIR					8841 Hele	na Road		2055885843					
4 City or town		5 State or prov	ince	6 Count	6 Country and ZIP or foreign postal code			1	12 State or p	province	foreign postal code				
CLARKSVILL	E	TN		US 37	7042		Pelham AL				US 35124				
		er of Cove	rage		Employee	's Age on						(enter 2-digit number):			
	All 12 Months	s 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	1A	1A		
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				
17 ZIP Code		ork Boduction							N- 00705M				1005 € (200		

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

Cat. No. 60705M

Instructions for Recipient

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	(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	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

Bethany D Lamkin 314 LAFAYETTE POINT CIR CLARKSVILLE, TN 37042

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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	rvice		Go to ww	w.irs.gov/For	m1095C for ins	structions ar	d the latest ir	formation.		Z © Z O						
Part I Emp	oloyee						Α	pplicable L	arge Empl	yer Meml	ber (Emplo	oyer)				
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security number	(SSN)	7 Name of emp	oloyer			8 E	Employer identification number (EIN)				
Bethany		D Lamk	in		XXX-XX-72	250	Apartment	Hunters, In		631031253						
3 Street address (i	ncluding apartr	ment no.)		•			9 Street addres	ss (including roc	Contact telephone number							
314 LAFAYET	TTE POINT	CIR					8841 Helena Road						2055885843			
4 City or town		5 State or pro	vince	6 Count	ry and ZIP or foreig	n postal code	11 City or town 12 State or province 13 C						or foreign postal code			
CLARKSVILL	E	TN		US 37	7042		Pelham		AL		US	US 35124				
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee's	mployee's Age on January 1 Plan Star					Start Month (enter 2-digit number):					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D							
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.

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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.

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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18											Guly	Aug	Серг					
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Part III. Covered Individuals, Lines 18–30

Elizabeth Diane Linkous 145 PARK PLACE CIRCLE ALABASTER, AL 35007

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.

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice			Go to ww	w.irs.go	v/Form	11095C for in:	structions a	nd the latest i	information.										
Part I Emp	oloyee									Applicable L	arge Emplo	yer Memb	er (Emplo	oyer)						
1 Name of employ	ee (first name,	middle	initial, las	t name)	2	Social	security number	r (SSN)	7 Name of em	nployer			8 E	mployer identific	cation number (EIN)					
Elizabeth		D	Linkou	IS			XXX-XX-57	739	Apartment	Hunters, In	C.			63103	1253					
3 Street address (including apartr	ment n	o.)		•				9 Street addre	ess (including roc	m or suite no.)		10 C	10 Contact telephone number						
145 PARK PL	ACE CIRC	LE							8841 Hele	na Road		2055885843								
4 City or town		5 Stat	te or provi	nce	6	6 Country and ZIP or foreign postal code			11 City or town	1	12 State or pro	ovince	13 C	13 Country and ZIP or foreign postal code						
ALABASTER		AL			U	JS 350	007		Pelham	AL		US	35124							
Part II Emp	oloyee Off	er of	Cover	age	*		Employee'		t Month (er	nter 2-digit	number):	09								
						1ar	Apr	May	June July		Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code)			1A	1A	1	Α	1A	1A	1A	1A	1A	1A	1A	1A	1A					
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
17 ZIP Code																				

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18											Guly	Aug	Серг					
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Part III. Covered Individuals, Lines 18–30

STEPHANIE R MACIAS 103 GLENWOOD PLACE SILOAM SPRINGS, AR 72761

Form	109:	5-C
	ment of the	

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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Internal Revenue Se	ervice		Go to ww	w.irs.gov/For	m1095C for in	structions a	ind the latest i	nformation.						
Part I Emp	oloyee						A	Applicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	nployer identifica	ation number (EIN)	
STEPHANIE		R MACIA	AS		XXX-XX-1	352	Apartment	Hunters, In	C.		631031253			
3 Street address (including apartr	nent no.)					9 Street addre	ess (including roc	10 Co	10 Contact telephone number				
103 GLENWO	OOD PLAC	E					8841 Hele	na Road		2055885843				
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or forei	y and ZIP or foreign postal code 11 City or town 12 State or province					13 Co	untry and ZIP or	foreign postal code	
SILOAM SPR	SILOAM SPRINGS AR						Pelham		US:	US 35124				
Part II Emp	oloyee Offe	er of Cover	age		Employee	's Age on	January 1		Plan Sta	rt Month (er	nter 2-digit r	number):	09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	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	
17 ZIP Code													1005 C assess	

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Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

LAVINA L MCDANIEL 121 MICHLI ROAD MADISON, AL 35758

OMB No. 1545-2251

Form	10	95	- C
Depart	ment o	of the T	reasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

DRRECTED 2023

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

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) **LAVINA** MCDANIEL XXX-XX-8738 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 121 MICHLI ROAD 8841 Helena Road 2055885843 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 ΑL Pelham **MADISON** US 35758 ΑI US 35124 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 Part II All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 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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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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- 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 covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov Dec				
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Part III. Covered Individuals, Lines 18–30

Katherine R Moore 236 SHADES CREST ROAD HOOVER, AL 35226

Form 1095- C	
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 Em	ployee						Aı	pplicable L	arge Emplo	yer Memb	er (Employ	yer)			
1 Name of employ	yee (first name,	middle initial, I	ast name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	ation number (EIN)		
Katherine		R Moor	e		XXX-XX-12	236	Apartment	Hunters, Inc		631031253					
3 Street address (including apartr	ment no.)					9 Street addres	ss (including roo	n or suite no.)		10 Co	10 Contact telephone number			
236 SHADES	CREST R	OAD					8841 Helena Road					2055885843			
4 City or town		5 State or pro	vince	6 Countr	ountry and ZIP or foreign postal code 11 City or town 12 State or province				13 Cou	13 Country and ZIP or foreign postal code					
HOOVER		AL		US 35	226		Pelham		AL		US 3	35124			
Part II Employee Offer of Coverage Employee's Age of							January 1		Plan Star	t Month (er	nter 2-digit n	r 2-digit number):			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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Cat. No. 60705M

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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

PHILLIP R MOORE 900 DOWNTOWNER BLVD 533 MOBILE, AL 36609

OMB No. 1545-2251

Form	1	O	9	5	-	C
Depar	tme	nt d	of th	ne T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

2023

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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) **PHILLIP** R MOORE XXX-XX-4905 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 900 DOWNTOWNER BLVD 533 8841 Helena Road 2055885843 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 Pelham **MOBILE** AL US 36609 ΑI US 35124 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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

RALPH MOORE 236 SHADES CREST ROAD HOOVER, AL 35226

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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.

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VOID

OMB No. 1545-2251

bo not attach to your tax return. Keep for your record

Go to $\emph{www.irs.gov/Form1095C}$ for instructions and the latest information.

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ree (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
RALPH		MOOI	RE		XXX-XX-5	503	Apartment Hunters, Inc.					631031253			
3 Street address (in	ncluding apartr	ment no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
236 SHADES	CREST R	OAD					8841 Helei	na Road				205588	5843		
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or	orovince	13 Co	ountry and ZIP or	foreign postal code		
HOOVER		AL		US 35	5226		Pelham		AL		US	35124			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit ı	number):	09		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			Ant Notice on										1005 C (222		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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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- **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).
- **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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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 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.																
	(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 Ken Nanbu 5206 PARKERSON RD APISON, TN 37302

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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	ervice		Go to www	irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	/ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 Er	nployer identifica	ation number (EIN)		
Michael		K Nanbu	J		XXX-XX-2	552	Apartment Hunters, Inc.					631031253			
3 Street address (i	including apartm	nent no.)		'			9 Street addres	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
5206 PARKEI	RSON RD						8841 Heler	na Road				205588	5843		
4 City or town	į	5 State or prov	nce	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP or	foreign postal code		
APISON	-	TN		US 37	' 302		Pelham		AL		US	US 35124			
Part II Emp	oloyee Offe	er of Cove	rage		Employee ³	s Age on c	lanuary 1		Plan Star	t Month (er	nter 2-digit ı	number):	09		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1A	1A	1A	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D				2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code													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).

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
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- 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.																
	(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

Jerome D Nelson 195 SALEM ROAD MONTEVALLO, AL 35115

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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.

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Part I Employee									Applicable Large Employer Member (Employer)										
1 Name of employe	e (first name,	middle	initial, las	t name)	2	Social s	security number	r (SSN)	7 Name of emp	loyer				8 Empl	oyer identificati	on number (EIN)			
Jerome		D	Nelsor	1		>	XXX-XX-22	281	Apartment I	Hunters, Inc					6310312	253			
3 Street address (in	cluding apartr	ment n	0.)						9 Street addres	s (including roon	n or suite no.)			10 Cont	act telephone n	umber			
195 SALEM R	OAD								8841 Helen	a Road				2055885843					
4 City or town		5 Stat	e or provir	nce	6 (Country a	and ZIP or forei	gn postal code	11 City or town		12 State or province			13 Country and ZIP or foreign postal code					
MONTEVALLO)	AL			US	S 351	15		Pelham		AL			US 35	5124				
							Employee'	s Age on J	lanuary 1		Plan Star	t Month (en	ter 2-d	igit nu	mber):	09			
All 12 Months Jan Feb Mar						ar	Apr	May	June	July	Aug	Sept	0	ct	Nov	Dec			
14 Offer of Coverage (enter required code)			1H	1H	11	Н	1H	1H	1H	1H	1H	1H	1	Н	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$	\$	\$	\$	\$	\$	\$		\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2/	A	2A	2A	2A	2A	2A	2A	2.	A					
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.



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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.

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Part I. Applicable Large Employer Member (Employer)

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

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

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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.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	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

CHIRIHANE F OUAOUA 130 NORRIDGE PLACE PELHAM, AL 35124

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Depar						,

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

2023

Internal Revenue Se	ervice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.								
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	yer)				
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	nployer identific	ation number (EIN)			
CHIRIHANE		F OUAC	AUC		XXX-XX-29	998	Apartment	Hunters, In-	C.			63103	1253			
3 Street address (i	including apartm	nent no.)		'			9 Street addre	ss (including roo	10 Co	10 Contact telephone number						
130 NORRIDO	GE PLACE						8841 Heler	na Road		2055885843						
4 City or town	5	5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code				
PELHAM								Pelham AL L					US 35124			
Part II Emp									Plan Sta	rt Month (e	nter 2-digit r	2-digit number): 09				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1H	1H	1H			
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17 ZIP Code			AdMaga										1005 0			

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

AMY L PEAKE 134 INDIANCREEK DRIVE PELHAM, AL 35124

Form	10	95	-C
Depar	tment	of the Tr	easury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in								
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 Er	nployer identific	ation number (EIN)		
AMY		L PEAK	E		XXX-XX-59	901	Apartment	Hunters, In-	C.			631031	1253		
3 Street address (i	including apartn	nent no.)					9 Street address	ss (including roo	10 Cd	10 Contact telephone number					
134 INDIANC	134 INDIANCREEK DRIVE							na Road		2055885843					
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
PELHAM								Pelham AL U							
Part II Emp	oloyee Offe	er of Cove	rage		Employee ³	s Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit ı	number):	09		
	All 12 Months Jan Feb Mar Apr							July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
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17 ZIP Code			A at Nation and										1005 C (2000)		

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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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

Shonda Maria Perez 4305 ST CLAIR DRIVE NE ALTANTA, GA 30329

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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						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Shonda		M Perez	, -		XXX-XX-0	157	Apartment	Hunters, Inc	C.			63103	1253		
3 Street address (in	ncluding apartn	nent no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
4305 ST CLAI	IR DRIVE I	ΝE					8841 Helena Road					2055885843			
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or forei	ign postal code	11 City or town 12 State or province				13 Cou	13 Country and ZIP or foreign postal code			
ALTANTA		GA		US 30	0329	Pelham AL					US 3	US 35124			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	09		
	All 12 Months Jan Feb Mar Apr N							July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	8	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code													1005 0		

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

Cat. No. 60705M

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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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1V. Reserved for future use.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

Rejon Macon Peters 6007 WHISPERING PINES DR BUFORD, GA 30518

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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

Internal Revenue Service	9		Go to www	.irs.gov/Forn	n1095C for ins	tructions an	a tne latest in	rormation.							
Part I Employ	yee						Ap	plicable L	arge Emplo	yer Membe	er (Emplo	yer)			
1 Name of employee (f	first name, n	middle initial, last	name)	2 Social	security number	(SSN)	7 Name of emp	loyer			8 Em	ployer identifica	tion number (EIN)		
Rejon		M Peters			XXX-XX-37	91	Apartment I	Hunters, Ind	3.			631031	253		
3 Street address (include	iding apartm	nent no.)					9 Street addres	s (including roo	m or suite no.)		10 Co	ntact telephone	number		
6007 WHISPERI	ING PINI	ES DR					8841 Helen	a Road				2055885843			
4 City or town	5	5 State or provin	ce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	12 State or province 13 C			Country and ZIP or foreign postal code		
BUFORD		GA		US 30!	518		Pelham		AL		US 3	35124			
Part II Employ	age	Employee's	Age on J	anuary 1		Plan Star	t Month (en	ter 2-digit n	er 2-digit number): 09						
All 12 Months Jan Feb Mar					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D												
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

GREGORY PETERSON 4073 NORTHRIDGE WAY APT 3 NORCROSS, GA 30093

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Part I Employee

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Service

GREGORY

4 City or town

NORCROSS

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

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

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) PETERSON XXX-XX-3296 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 4073 NORTHRIDGE WAY APT 3 8841 Helena Road 2055885843 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 US 30093 Pelham AL US 35124

Part II Emp	Part II Employee Offer of Coverage				Employee'	s Age on J	anuary 1		Plan Star	09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter 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.
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

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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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/	A POPA			XXX-XX-39	Apartment	Hunters, Ind		631031253					
ncluding apartm	ent no.)		•			9 Street addres	ss (including roo	1	10 Contact telephone number				
CREST DR	IVE					8841 Heler	na Road		2055885843				
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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.

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

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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.

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) Marque D Raiford XXX-XX-0685 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 10862 NICHOLS BLVD BLDG 13 APT 5 8841 Helena Road 2055885843 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 Pelham **OLIVE BRANCH** MS US 38654 ΑI US 35124 Part II Employee Offer of Coverage **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

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

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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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- **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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- 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.

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

JESSICA SANTIAGO-VARGAS 285 TWIN OAKS DRIVE NASHVILLE, TN 37211

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17 ZIP Code

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

CORRECTED

VOID

OMB No. 1545-2251 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) **JESSICA SANTIAGO-VARGAS** XXX-XX-1511 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 285 TWIN OAKS DRIVE 8841 Helena Road 2055885843 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 **NASHVILLE** Pelham TN US 37211 ΑI US 35124 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1H 1H 1H 1H 1H 1H 1H 1A 1H 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2A 2A code, if applicable) 2A

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.



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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.

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

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

BRANDI SHARIT 101 GREEN WING CIRCLE PELHAM, AL 35124

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

Part I Employee

BRANDI

4 City or town

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

3 Street address (including apartment no.)

101 GREEN WING CIRCLE

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records. Internal Revenue Service

SHARIT

5 State or province

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

6 Country and ZIP or foreign postal code 11 City or town

2 Social security number (SSN)

XXX-XX-2629

2023 Applicable Large Employer Member (Employer) 8 Employer identification number (EIN) Apartment Hunters, Inc. 631031253 9 Street address (including room or suite no.) 10 Contact telephone number 2055885843 13 Country and ZIP or foreign postal code 12 State or province 110 25124

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PELHAM				US 35	S 35124 Pelham				AL		US 3	US 35124		
Part II Emp	oloyee Offe	r of Cover	age	,	Employee's Age on January 1					t Month (en	ter 2-digit n	umber):	09	
	All 12 Months	Jan	Feb	Mar	Apr May June July			July	Aug	Sept	Oct	Oct Nov		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														

7 Name of employer

8841 Helena Road

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

Cat. No. 60705M

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Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

ORENTHAL JAMES SIMPSON 264 NEWPORT ROAD SW LILBURN, GA 30047

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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	/.irs.gov/Foi	m 1095C for II	istructions ar	ia the latest i	ntormation.				1 -				
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	oyer)				
1 Name of employ	ee (first name, m	niddle initial, la	ıst name)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)			
ORENTHAL		J SIMP	SON		XXX-XX-2	182	Apartment Hunters, Inc.					63103	1253			
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ess (including roc	m or suite no.)		10 C	10 Contact telephone number				
264 NEWPOR	RT ROAD S	W					8841 Helei	na Road				205588	5843			
4 City or town	5	State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town 12 State or province					ountry and ZIP or	foreign postal code			
LILBURN		GΑ		US 30	0047		Pelham		AL		US	35124				
Part II Emp	loyee Offe	r of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code			Act Notice se										a 1095-C /202			

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

Cat. No. 60705M

Instructions for Recipient

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



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

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

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Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	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

VICKI B SIMS 228 RIVERBEND DRIVE UNIT 228 MOBILE, AL 36605

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

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						А	pplicable L	arge Empl	oyer Memb	ber (Empl	oyer)				
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer			8 1	Employer identifica	ation number (EIN)			
VICKI		B SIMS			XXX-XX-97	755	Apartment	Hunters, In-	C.			63103	1253			
3 Street address (i	ncluding apartm	nent no.)		<u>'</u>			9 Street addre	ess (including roo	10 (10 Contact telephone number						
228 RIVERBE	END DRIVE	UNIT 228					8841 Helena Road					2055885843				
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign postal c						11 City or town 12 State or province				13 (13 Country and ZIP or foreign postal code				
MOBILE								05 Pelham AL					US 35124			
Part II Emp	oloyee Offe	er of Cove	rage	Employee'	s Age on .	January 1		Plan Sta	rt Month (e	enter 2-digit	t number):	09				
All 12 Months Jan Feb Mar Apr Ma							June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
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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	(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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CHOLOM SNOW 978 SENTRY COURT LAWRENCEVILLE, GA 30043

Form	109:	5-C
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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 Emp	loyer Meml	oer (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ıployer			8 Er	nployer identific	ation number (EIN)		
CHOLOM		SNOV	V		XXX-XX-9	435	Apartment Hunters, Inc.					631031253			
3 Street address (in	ncluding apartr	nent no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number			
978 SENTRY	COURT						8841 Helei	na Road				205588	5843		
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town 12 State or province			13 Cd	13 Country and ZIP or foreign postal code				
LAWRENCEVILLE GA US 30043					Pelham AL				US	US 35124					
Part II Employee Offer of Coverage Employee's Ag						's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	2-digit number): 09			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
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17 ZIP Code													1005 0		

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Cat. No. 60705M

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Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

SHERYL A STRAYHORN JOHNSON 4129 SIDLEHILL DRIVE OLIVE BRANCH, MS 38654

Form 1095-0	
Form IUJJ-	J
Department of the Treasu	ıry
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.

Part I Emp	Employee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name,	middle initial, l	ast name)	2 Socia	security numbe	r (SSN)	7 Name of em	ployer			8 En	nployer identificat	ion number (EIN)		
SHERYL		A STR	AYHORN JO	HNS	XXX-XX-50	074	Apartment	Hunters, Inc	. .			631031253			
3 Street address (i	including apart	ment no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number			
4129 SIDLEH	ILL DRIVE	-					8841 Helei	na Road				2055885843			
4 City or town		5 State or pro	vince	6 Country	y and ZIP or forei	gn postal code	11 City or town 12 State or province				13 Co	untry and ZIP or fo	oreign postal code		
OLIVE BRAN	CH	MS		US 38	654		Pelham AL					35124			
Part II Employee Offer of Coverage Employee's Age of						s Age on c	January 1		Plan Star	t Month (en	ter 2-digit r	number):	09		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter 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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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 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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- 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.

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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	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

HOLLY S TAFT 9228 BERKSHIRE CIRCLE CHATTANOOGA, TN 37421

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

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

PRRECTED 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) **HOLLY** S TAFT XXX-XX-1475 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 9228 BERKSHIRE CIRCLE 8841 Helena Road 2055885843 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 Pelham **CHATTANOOGA** TN US 37421 ΑI US 35124 Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 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 covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

MARK TAYLOR 5009 EASTVIEW TER APISON, TN 37302

Form 1095-C	
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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1 Name of employe	ee (first name, r	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
MARK		TAYL	OR		XXX-XX-4	758	Apartment	Hunters, In		631031253					
3 Street address (in	ncluding apartm	nent no.)					9 Street addre	ess (including roo	om or suite no.)		10 Co	10 Contact telephone number			
5009 EASTVII	5009 EASTVIEW TER							na Road				2055885843			
4 City or town	į	5 State or provi	nce	6 Count	6 Country and ZIP or foreign postal code				12 State or	province	13 Co	13 Country and ZIP or foreign postal code			
APISON	-	TN		US 37	US 37302				AL		US	US 35124			
Part II Emp	loyee Offe	er of Cover	rage		Employee	's Age on	January 1		Plan Sta	art Month (e	nter 2-digit	number):	09		
	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)		2A	2A	2A	2A	2D									
17 ZIP Code			And Nation on										1005 C (222		

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

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of 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

LISA TESTMAN 1708 BROOMFIELD WAY LAWRENCEVILLE, GA 30044

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
LISA		TEST	MAN		XXX-XX-9	627	Apartment	Hunters, In-		631031253					
3 Street address (in	3 Street address (including apartment no.)								m or suite no.)		10 C	ontact telephone	number		
1708 BROOM	IFIELD WA	ΔΥ					8841 Helei	na Road				205588	5843		
4 City or town 5 State or province 6 Country and ZIP or foreign postal co						ign postal code	11 City or town 12 State or province				13 Cd	ountry and ZIP or	foreign postal code		
LAWRENCEV	/ILLE	GA		US 30	0044		Pelham AL					US 35124			
Part II Emp	oloyee Off	er of Cove	rage	Employee	's Age on .	January 1	irt Month (e	nter 2-digit	number):	09					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
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.

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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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
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	(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

Banks Nathan Thomas 1036 ARLENE DR LA VERONE, TN 37086

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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 WW	/w.irs.gov/For	m 1095C for i	nstructions a	nd the latest i	intormation.							
Part I Em	ployee						<i>P</i>	Applicable I	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	yee (first name,	middle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	nployer			8 Er	nployer identifica	ation number (EIN)		
Banks		N Thom	as		XXX-XX-2	2997	Apartment	t Hunters, In		631031	253				
3 Street address (including apart	ment no.)		•			9 Street addre	ess (including roo	om or suite no.)		10 Cd	10 Contact telephone number			
1036 ARLEN	1036 ARLENE DR							na Road		2055885843					
4 City or town		5 State or prov	ince	6 Count	6 Country and ZIP or foreign postal code			า	12 State or p	province	13 Co	13 Country and ZIP or foreign postal code			
LA VERONE		TN		US 37	7086		Pelham		AL		US	35124			
Part II Em	ployee Off	er of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (er	nter 2-digit ı	number):	09		
	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	1A	1A	1A	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D				2A	2A	2A	2A	2A	2A		
17 ZIP Code															
													400F O		

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

Cat. No. 60705M

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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jemicheal Trayvond Thomas 2529 AVENUE B BIRMINGHAM, AL 35218

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17 ZIP Code

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 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) Jemicheal Т Thomas XXX-XX-7433 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2529 AVENUE B 8841 Helena Road 2055885843 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 Pelham **BIRMINGHAM** AL US 35218 ΑI US 35124 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 Part II All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H 1A 1A 1A 1H 1H required code) 1A 1A 1A 1A 1A 1H 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2A 2A 2A code, if applicable)

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

Cat. No. 60705M

Instructions for Recipient

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

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

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- 1X. Reserved for future use.
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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BETTY ANNETTE WADE 483 WHISPERING PINES LANE HELENA, AL 35080

Form	095-	-C
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Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
BETTY		a Wade	<u>=</u>		XXX-XX-2	XX-XX-2410 Apartment Hunters, Inc.						631031253			
3 Street address (in	ncluding apartm	nent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
483 WHISPER	RING PINE	S LANE					8841 Helei	na Road				2055885843			
4 City or town	5	State or prov	ince	6 Count	6 Country and ZIP or foreign postal code				12 State or	province	13 Co	ountry and ZIP or	foreign postal code		
HELENA		AL		US 35	US 35080				AL		US	US 35124			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	nter 2-digit	number):	09		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
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17 ZIP Code			A at Nation										1005 C (222		

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ERIC J WALKER 105 SOUTH RUN CIRCLE HOOVER, AL 35244

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Employer-Provided Health Insurance Offer and Coverage

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	/ee (first name, ı	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 En	nployer identifica	tion number (EIN)	
ERIC		J WAL	KER		XXX-XX-6	394	Apartment	Hunters, In		631031253				
3 Street address (i	including apartn	nent no.)		•			9 Street addre	ss (including roc	10 Cd	10 Contact telephone number				
105 SOUTH F	RUN CIRCL	.E					8841 Heler	na Road				205588	5843	
4 City or town	4 City or town 5 State or province 6					gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	oreign postal code	
HOOVER AL US 35244							Pelham		AL		US	35124		
Part II Employee Offer of Coverage Employee's Age of							January 1		Plan Sta	rt Month (er	nter 2-digit r	er 2-digit number): (
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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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.

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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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

BRITTANY A WALLACE 270 BESHEARS DR SE HUNTSVILLE, AL 35803

OMB No. 1545-2251

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

Internal Revenue Se	Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.															
Part I Emp	oloyee							Ap	oplicable La	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initia	al, last name		2 Social	I security numbe	r (SSN)	7 Name of emp	loyer			8 E	mployer identific	ation number (EIN)		
BRITTANY		A W	ALLACE			XXX-XX-57	768	Apartment I	Hunters, Inc				63103°	1253		
3 Street address (i	3 Street address (including apartment no.)							9 Street addres	s (including roor	n or suite no.)		10 C	10 Contact telephone number			
270 BESHEARS DR SE							8841 Helen	a Road				2055885843				
4 City or town 5 State or province 6 Country and ZIP or foreign postal of					gn postal code	11 City or town 12 State or province 13					ountry and ZIP or	foreign postal code				
HUNTSVILLE AL US 35803							Pelham		AL		US	35124				
Part II Emp	oloyee Offe	er of Co	verage		·	Employee'	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit	digit number): 09			
	All 12 Months	Jar	n	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1.4	A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code										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.

- **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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- **10.** Individual coverage HRA offered to you only 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.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

Ainsley S Walls 3840 S QUAIL LANE CHATTANOOGA, TN 37415

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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 Emplo	Part I Employee									Applicable Large Employer Member (Employer)													
1 Name of employee	e (first name,	middle	initial, las	st name)		2 Social	secu	urity number	(SSN)	7	7 Name of emp	loye	er						8 Emp	loye	r identificatio	n number (EIN)
Ainsley		S	Walls				XX	X-XX-05	503	P	Apartment I	Нu	nters, Inc								6310312	53	
3 Street address (inc	cluding apartr	ment n	o.)							9	9 Street address	s (ir	ncluding room	n or s	uite no.)				10 Cont	tact t	telephone nu	mber	
3840 S QUAIL	LANE									8	8841 Helen	a F	Road							2	20558858	43	
4 City or town		5 Stat	te or provi	nce		6 Country	and	ZIP or foreig	n postal code	1	1 City or town			12	State or pro	vince			13 Coun	itry a	nd ZIP or fore	ign postal	code
CHATTANOOGA TN US 37415						F	Pelham			AL	_				US 3	512	24						
Part II Emplo	oyee Offe	er of	Cover	age			Em	ployee's	s Age on	Ja	anuary 1			PI	an Start	Mor	ith (en	ter 2	2-digit number): 09				
	All 12 Months		Jan	Feb		Mar		Apr	May		June		July		Aug	S	ept		Oct		Nov	Dec	
14 Offer of Coverage (enter required code)			1H	1H		1H		1H	1H		1A		1A		1A	1	Α		1A		1A	1A	
15 Employee Required Contribution (see instructions)	3	\$		\$	\$		\$		\$		\$	\$		\$		\$		\$		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A		2A		2A	2D														
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.

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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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Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

Joshua M Watson 170 BIRMINGHAM ST, LOT 3 MONTEVALLO, AL 35115

Form	109:	5-C
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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.

CORRECTED | 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 M Watson XXX-XX-0115 Apartment Hunters, Inc. 631031253 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 170 BIRMINGHAM ST LOT 3 8841 Helena Road 2055885843 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 US 35115 Pelham **MONTEVALLO** AL ΑI US 35124 Part II Employee Offer of Coverage **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 09 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H 1H 1H 1H 1H 1H 1A 1H 1H 1A 1A 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2D code, if applicable) 2A 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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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.

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Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	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

Thomas Watson 644 OLIVE BRANCH ROAD SMYRNA, TN 37167

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

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OMB No. 1545-2251

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Part I Emp	ployee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)						
1 Name of employ	ee (first name,	middle initial, l	ast name)	2 Soc	ial security num	nber (SSN)	7 Name of em	ployer			8 E	mployer identifi	cation number (EIN)					
Thomas		Wats	on		XXX-XX	-6831	Apartment	Hunters, In	C.			63103	1253					
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ss (including roo	om or suite no.)		10 C	10 Contact telephone number						
644 OLIVE BI	RANCH RO	DAD					8841 Helei	na Road				2055885843						
4 City or town		5 State or pro	vince	6 Coun	try and ZIP or fo	oreign postal code	11 City or town		12 State or p	province	13 Co	13 Country and ZIP or foreign postal code						
SMYRNA		TN		US 3	7167		Pelham AL US 35124											
Part II Emp	ployee Off	er of Cove	erage	•	Employe	e's Age on	January 1	January 1 Plan Start Month (ent					2-digit number): 09					
All 12 Months Jan Feb Mar Apr						May	June	July	Aug Sept C			Nov	Dec					
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1H	1H					
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D			2A	2A					
17 ZIP Code																		

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JASON WELDON 116 CEDAR COVE DRIVE PELHAM, AL 35124

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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 Emp	loyer Mem	ber (Empl	oyer)			
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)		
JASON		WELD	OON		XXX-XX-6	333	Apartment	Hunters, In	C.			63103°	1253		
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ess (including roc	m or suite no.)		10 0	10 Contact telephone number			
116 CEDAR C	OVE DRIV	Έ					8841 Hele	na Road		2055885843					
4 City or town	5	State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town 12 State or province					ountry and ZIP or	foreign postal code		
PELHAM		AL		US 3	5124		Pelham		AL		US	35124			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	09		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A Act Notice on						No. 00705M				- 1005 C (2000)		

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- 1Z. Reserved for future use.

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	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

Jerome Leon Westry 523 ROSEMONT DRIVE SARALAND, AL 36571

Form	10	<i>)</i> 9;	5 –	C
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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.

Part I Emp	Part I Employee							Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middl	e initial, las	t name)	2 Soc	cial security no	ımber (SSN)	7 Name of e	mployer			8	Employ	yer identificati	on number (EIN)		
Jerome		L	Westry	,		XXX-X	K-5441	Apartmer	nt Hunters, In	C.				6310312	253		
3 Street address (i	including apart	ment r	10.)		<u>'</u>			9 Street add	lress (including roo	m or suite no.)		10	Contac	ct telephone n	umber		
523 ROSEMO	ONT DRIVE	Ξ						8841 Hel	ena Road				2055885843				
4 City or town		5 Sta	te or provi	nce	6 Cou	ntry and ZIP or	foreign postal cod	e 11 City or tov	vn	12 State or pr	ovince	13	13 Country and ZIP or foreign postal code				
SARALAND		AL			US 3	36571	Pelham AL							US 35124			
Part II Emp								January 1		Plan Star	t Month (en	ter 2-dig	jit num	09			
	All 12 Months	3	Jan	Feb	Mar	Apı	May	June	July	Aug	Sept	Oct		Nov	Dec		
14 Offer of Coverage (enter required code)			1A	1A	1A	14	1A	1A	1A	1A	1A	1A		1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$;	\$		
16 Section 4980H Safe Harbor and Other Relief (enter 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.
- **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.

Par	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov Dec		
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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

Apartment Hunters, Inc. 8841 Helena Road Pelham, AL 35124

Rachel Wray 291 FOREST PARKWAY ALABASTER, AL 35007

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Interna	al Reve	nue Ser	vice

Employer-Provided Health Insurance Offer and Coverage

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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.gov/Fori	1110950 101 111	Structions ar	iu trie latest li	mormation.				`		
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	I security numbe	er (SSN)	7 Name of em	ployer	8 Er	8 Employer identification number (EIN)				
Rachel		Wray			XXX-XX-0	139	Apartment	Hunters, Inc	C.			631031253		
3 Street address (in	3 Street address (including apartment no.)							ss (including roo	m or suite no.)		10 C	ontact telephone	number	
291 FOREST	291 FOREST PARKWAY							na Road				205588	35843	
4 City or town	5	State or provi	nce	6 Countr	ntry and ZIP or foreign postal code 11 City or town 12 State or province					13 Co	ountry and ZIP or	foreign postal code		
ALABASTER	A	AL		US 35	007		Pelham		AL		US	35124		
Part II Emp	loyee Offe	r of Cover	rage		Employee'	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	09	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D												
17 ZIP Code													1005.0	

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

Cat. No. 60705M

Form **1095-C** (2023)

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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- **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.
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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.

(continued on page 4)

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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											Dec	
18												Aug	Серг			
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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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 13 covered individuals, additional copies of page 3 may be used.

Apartment Hunters, Inc. 8841 Helena Road Pelham, AL 35124

LAUREN M ZANONE 3576 HAVEN STREET CINCINNATI, OH 45220

Form	095-	-C
	ent of the Tre	

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.

PRRECTED 2023

Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)		
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer	8 Em	8 Employer identification number (EIN)				
LAUREN M ZANONE XXX-XX-7931							Apartment	Hunters, In-	C.			631031253		
3 Street address (i	3 Street address (including apartment no.)							ss (including roo	m or suite no.)		10 Co	10 Contact telephone number		
3576 HAVEN	STREET						8841 Heler	na Road				205588	35843	
4 City or town	:	5 State or prov	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	13 Co	untry and ZIP or	foreign postal code	
CINCINNATI		ОН		US 45	5220		Pelham		AL		US:	35124		
Part II Emp	oloyee Offe	er of Cove	rage		Employee ³	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit r			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			AdMillion										1005 0	

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

Cat. No. 60705M

Form **1095-C** (2023)

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.

(continued on page 4)

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	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											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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 13 covered individuals, additional copies of page 3 may be used.