

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Phillip Ammons  
9014 GA Hwy 39  
Omaha, GA 31821



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Phillip Ammons |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-1268        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>9014 GA Hwy 39                 |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Omaha  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31821 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | 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  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|---------|--|--------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |         |  |        |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Phillip |  | Ammons | XXX-XX-1268          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |         |  |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Walter Bennett IV  
7118 GA Hwy 39  
Omaha, GA 31821





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**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Walter Bennett |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-8990        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>7118 GA Hwy 39                 |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Omaha  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31821 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | 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  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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.

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| (a) Name of covered individual(s)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|--------|--|---------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |        |  |         |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Walter |  | Bennett | XXX-XX-8990          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | HANNAH |  | BENNETT | XXX-XX-5842          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |        |  |         |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Brittany D Burns  
100 Epps Ct  
Seale, AL 36875



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Brittany D Burns |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-6127        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>100 Epps Ct                      |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Seale  |               | 5 State or province<br>AL |     | 6 Country and ZIP or foreign postal code<br>US 36875 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | All 12 Months | Jan                       | Feb | Mar  | Apr | May | June   | July | Aug   | Sept | Oct   | Nov | Dec |
| 14 Offer of Coverage (enter required code)                                     |               | 1H                        | 1H  | 1H   | 1H  | 1H  | 1H   | 1H   | 1H  | 1H   | 1H  | 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   | 2D  |     |     |
| 17 ZIP Code  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)



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)<br>First name, middle initial, last name |  |  |  | (b) SSN or other TIN | (c) DOB (if SSN or other<br>TIN is not available) | (d) Covered<br>all 12 months | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|---|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |   |                              | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

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**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Cynthia S Farmer  
1727 Lee Road 360  
Valley, AL 36854



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Cynthia S Farmer |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-0182        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>1727 Lee Road 360                |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Valley   |               | 5 State or province<br>AL |     | 6 Country and ZIP or foreign postal code<br>US 36854 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | 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  | 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                        | 2A  | 2A   | 2D  |     |  |      |   |      |   |     |     |
| 17 ZIP Code  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>First name, middle initial, last name |  |  |  | (b) SSN or other TIN | (c) DOB (if SSN or other<br>TIN is not available) | (d) Covered<br>all 12 months | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|---|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |   |                              | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Robbert Farmer  
1727 Lee Road 360  
Valley, AL 36854



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|---|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Robbert     |               |                           | 2 Social security number (SSN)<br>XXX-XX-3584 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>1727 Lee Road 360           |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Valley  |               | 5 State or province<br>AL |   | 6 Country and ZIP or foreign postal code<br>US 36854 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|   | 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   |               |                           |   |  |     |  |      |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|---------|---|--------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |         |   |        |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Robbert |   | Farmer | XXX-XX-3584          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | Cynthia | S | Farmer | XXX-XX-0182          |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Donald Feagins  
PO Box 133  
Cottonton, AL 36851





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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|--|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Donald Feagins |               |                           | 2 Social security number (SSN)<br>XXX-XX-9486 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>PO Box 133                     |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Cottonton  |               | 5 State or province<br>AL |   | 6 Country and ZIP or foreign postal code<br>US 36851 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage   |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|  | 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  |               |                           |   |  |     |  |      |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>First name, middle initial, last name |        |  |         | (b) SSN or other TIN | (c) DOB (if SSN or other<br>TIN is not available) | (d) Covered<br>all 12 months | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|--------|--|---------|----------------------|---|------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |        |  |         |                      |   |                              | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Donald |  | Feagins | XXX-XX-9486          |   | <input type="checkbox"/>     | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |        |  |         |                      |   | <input type="checkbox"/>     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Daniel Fletcher  
5 Milton Court  
Columbus, GA 31904



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Daniel Fletcher |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-1176        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>5 Milton Court                  |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Columbus  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31904 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)



**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|----|--|--|----------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|    |  |  |          |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18 | Daniel   |  | Fletcher | XXX-XX-1176          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19 | ALLISON  |  | FLETCHER | XXX-XX-0113          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30 |  |  |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Samantha F King  
16 Lakeside Ct  
Pittsview, AL 36871



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Samantha F King |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-0607        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>16 Lakeside Ct                  |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Pittsview   |               | 5 State or province<br>AL |     | 6 Country and ZIP or foreign postal code<br>US 36871 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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  | 1H  | 1H  |
| 15 Employee Required Contribution (see instructions)                          | \$            | \$                        | \$  | \$   | \$  | \$  | \$   | \$   | \$  | \$   | \$  | \$  | \$  |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)     |               |                           |     |  |     |     |  |      |   |      |   | 2A  | 2A  |
| 17 ZIP Code   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                          |                          |
|--|----------|---|------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|
|  |          |   |      |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                      | Dec                      |
| 18   | Samantha | F | King | XXX-XX-0607          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   | Addyson  |   | King | XXX-XX-6179          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   | Eric     |   | King | XXX-XX-1130          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   | Karson   |   | King | XXX-XX-9980          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   | Kaston   | 0 | King | XXX-XX-7048          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |          |   |      |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Laura K Logan  
65 Lakeview dr  
Pittsview, AL 36871



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Laura K Logan |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-7493        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>65 Lakeview dr                |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Pittsview   |               | 5 State or province<br>AL |     | 6 Country and ZIP or foreign postal code<br>US 36871 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|----|--|---|----------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|    |  |   |          |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18 | Laura  | K | Logan    | XXX-XX-7493          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19 | Thomas   | B | Logan JR | XXX-XX-9489          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20 | Kaylee   |   | Logan    | XXX-XX-5963          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30 |  |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Dylan E Lopez  
207 West Main Street  
Plains, GA 31780





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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|---|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Dylan E Lopez |               |                           | 2 Social security number (SSN)<br>XXX-XX-9228 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>207 West Main Street          |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Plains  |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31780 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|   | All 12 Months | Jan                       | Feb   | Mar  | Apr | May  | June | July  | Aug   | Sept  | Oct | Nov | Dec |
| 14 Offer of Coverage (enter required code)                                  |               | 1H                        | 1H  | 1H   | 1H  | 1H   | 1H   | 1H  | 1H  | 1H  | 1H  | 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  | 2D  |     |     |
| 17 ZIP Code   |               |                           |   |  |     |  |      |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>First name, middle initial, last name |  |  |  | (b) SSN or other TIN | (c) DOB (if SSN or other<br>TIN is not available) | (d) Covered<br>all 12 months | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|---|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |   |                              | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |   | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Derek Lynch  
5793 Ga Hwy 39  
Omaha, GA 31821



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|--|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Derek      Lynch |               |                           | 2 Social security number (SSN)<br>XXX-XX-0912 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>5793 Ga Hwy 39                   |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Omaha  |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31821 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage   |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|  | 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  |               |                           |   |  |     |  |      |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)



**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|----------|---|-------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |          |   |       |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Derek    |   | Lynch | XXX-XX-0912          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | DEACON   |   | LYNCH | XXX-XX-7706          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   | Alice    |   | Lynch | XXX-XX-3802          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21   | ELIZA    |   | LYNCH | XXX-XX-1182          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 22   | PAISLEY  | O | LYNCH | XXX-XX-3033          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 23   | CARALINE | H | LYNCH | XXX-XX-7539          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 24   | Jonna    | V | Lynch | XXX-XX-7004          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 25   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |          |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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**

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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Jonna V Lynch  
5793 GA HWY 39  
Omaha, GA 31821



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Jonna V Lynch |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-7004        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>5793 GA HWY 39                |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Omaha   |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31821 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

William A Miller  
210 Dorrough Rd S  
Cordele, GA 31015



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>William A Miller |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-3721        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>210 Dorough Rd S                 |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Cordele  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31015 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | All 12 Months | Jan                       | Feb | Mar  | Apr | May | June   | July | Aug   | Sept | Oct   | Nov | Dec |
| 14 Offer of Coverage (enter required code)                                     |               | 1H                        | 1H  | 1H   | 1H  | 1H  | 1H   | 1H   | 1H  | 1H   | 1H  | 1H  | 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  | 2D  |     |
| 17 ZIP Code  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Walter Pearce  
3237 Holtzclaw Rd  
Omaha, GA 31821





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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |     |   |     |     |     |
|---|---------------|---------------------------|---|--|--|-----------------------------|---|---|-----|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Walter Pearce |               |                           | 2 Social security number (SSN)<br>XXX-XX-0755 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |     |   |     |     |     |
| 3 Street address (including apartment no.)<br>3237 Holtzclaw Rd             |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |     |   |     |     |     |
| 4 City or town<br>Omaha   |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31821 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |     | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |  |                             |   | Plan Start Month (enter 2-digit number): 01         |     |   |     |     |     |
|   | 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   |               |                           |   |  |  |                             |   |   |     |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|--------|---|--------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |        |   |        |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Walter |   | Pearce | XXX-XX-0755          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | KATIE  | L | PEARCE | XXX-XX-8350          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |        |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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**

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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Brandon Peavy  
PO Box 23  
Omaha, GA 31821



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

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

☐ VOID

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OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |   |   |     |     |     |
|---|---------------|---------------------------|---|--|--|-----------------------------|---|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Brandon     |               |                           | 2 Social security number (SSN)<br>XXX-XX-8648 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |   |   |     |     |     |
| 3 Street address (including apartment no.)<br>PO Box 23                   |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |   |   |     |     |     |
| 4 City or town<br>Omaha   |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31821 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |  |                             |   |   | Plan Start Month (enter 2-digit number): 01 |   |     |     |     |
|   | 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   |               |                           |   |  |  |                             |   |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)



**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|---------|---|-------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |         |   |       |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Brandon |   | Peavy | XXX-XX-8648          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | ALLISON | W | PEAVY | XXX-XX-6979          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |         |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Jeanine D Peavy  
7780 Ga Hwy 39  
Omaha, GA 31821



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Jeanine D Peavy |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-4076        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>7780 Ga Hwy 39                  |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Omaha   |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31821 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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   | 1H  | 1H  | 1H   | 1H   | 1H  | 1H   | 1H  | 1H  | 1H  |
| 15 Employee Required Contribution (see instructions)                          | \$            | \$                        | \$  | \$   | \$  | \$  | \$   | \$   | \$  | \$   | \$  | \$  | \$  |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)     |               |                           |     |  | 2A  | 2A  | 2A   | 2A   | 2A  | 2A   | 2A  | 2A  | 2A  |
| 17 ZIP Code   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|----|--|---|-------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|    |  |   |       |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18 | Jeanine  | D | Peavy | XXX-XX-4076          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Caleb A Scott  
260 Bob Savel Rd  
Buena Vista, GA 31803



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |   |   |     |     |     |
|---|---------------|---------------------------|---|--|--|-----------------------------|---|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Caleb A Scott |               |                           | 2 Social security number (SSN)<br>XXX-XX-9914 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |   |   |     |     |     |
| 3 Street address (including apartment no.)<br>260 Bob Savel Rd              |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |   |   |     |     |     |
| 4 City or town<br>Buena Vista   |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31803 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |  |                             |   |   | Plan Start Month (enter 2-digit number): 01 |   |     |     |     |
|   | 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  | 1A  | 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  | 2D  |   |   |     |     |     |
| 17 ZIP Code   |               |                           |   |  |  |                             |   |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                                     |                                     |                                     |                                     |                                     |
|----|--|---|-------|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|    |  |   |       |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18 | Caleb  | A | Scott | XXX-XX-9914          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30 |  |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Jonathan Screws  
1867 Wall Road  
Omaha, GA 31821





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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|--|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Jonathan      Screws |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-3128        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>1867 Wall Road                       |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Omaha  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31821 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage   |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|  | 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  |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|----|--|---|--------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|    |  |   |        |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18 | Jonathan   |   | Screws | XXX-XX-3128          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19 | NIYA   |   | SCREWS | XXX-XX-6417          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20 | TWYLAR   | P | SCREWS | XXX-XX-6099          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30 |  |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Jeffrey G Smith  
260 Thrasher Road  
Plains, GA 31780



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.

Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |                            |      |   |     |     |  |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|----------------------------|------|---|-----|-----|--|
| 1 Name of employee (first name, middle initial, last name)<br>Jeffrey G Smith |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-2590        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |                            |      | 8 Employer identification number (EIN)<br>581942486   |     |     |  |
| 3 Street address (including apartment no.)<br>260 Thrasher Road               |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |                            |      | 10 Contact telephone number<br>7065713405             |     |     |  |
| 4 City or town<br>Plains  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31780 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |  |
| Part II Employee Offer of Coverage  |               |                           |     |  |     |     | Employee's Age on January 1                                  |      |                            |      | Plan Start Month (enter 2-digit number): 01           |     |     |  |
|   | 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   | 1H  | 1H  | 1H   | 1H   | 1H                         | 1H   | 1H  | 1H  | 1H  |  |
| 15 Employee Required Contribution (see instructions)                          | \$            | \$                        | \$  | \$   | \$  | \$  | \$   | \$   | \$                         | \$   | \$  | \$  | \$  |  |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)     |               |                           |     |  | 2A  | 2A  | 2A   | 2A   | 2A                         | 2A   | 2A  | 2A  | 2A  |  |
| 17 ZIP Code   |               |                           |     |  |     |     |  |      |                            |      |   |     |     |  |

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](http://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](http://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).

**1I.** 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.

**1O.** 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)



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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Judy Smith  
306 Lee Rd 942  
Smiths Station, AL 36877



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |      |   |      |   |     |     |
|---|---------------|---------------------------|-----|--|-----|-----|--|------|---|------|---|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Judy Smith  |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-3224        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   |      | 8 Employer identification number (EIN)<br>581942486   |     |     |
| 3 Street address (including apartment no.)<br>306 Lee Rd 942              |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   |      | 10 Contact telephone number<br>7065713405             |     |     |
| 4 City or town<br>Smiths Station  |               | 5 State or province<br>AL |     | 6 Country and ZIP or foreign postal code<br>US 36877 |     |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  |      | Plan Start Month (enter 2-digit number): 01 |      |   |     |     |
|   | 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   |               |                           |     |  |     |     |  |      |   |      |   |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|------|--|-------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |      |  |       |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Judy |  | Smith | XXX-XX-3224          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |      |  |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Jacob Stillwell  
4098 Sandfort Road  
Phenix City, AL 36869



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☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |     |   |     |     |     |
|---|---------------|---------------------------|---|--|--|-----------------------------|---|---|-----|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Jacob       |               |                           | 2 Social security number (SSN)<br>XXX-XX-9970 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |     |   |     |     |     |
| 3 Street address (including apartment no.)<br>4098 Sandfort Road          |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |     |   |     |     |     |
| 4 City or town<br>Phenix City   |               | 5 State or province<br>AL |   | 6 Country and ZIP or foreign postal code<br>US 36869 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |     | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |  |                             |   | Plan Start Month (enter 2-digit number): 01         |     |   |     |     |     |
|   | 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   |               |                           |   |  |  |                             |   |   |     |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.

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**1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.

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

**1S.** Individual coverage HRA offered to an individual who was not a full-time employee.

**1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.

**1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.

**1V.** Reserved for future use.

**1W.** Reserved for future use.

**1X.** Reserved for future use.

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

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

(continued on page 4)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|----|--|--|-----------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|    |  |  |           |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18 | Jacob  |  | Stillwell | XXX-XX-9970          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30 |  |  |           |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Ashley Sexton Turner  
7003 Stone Ct  
Columbus, GA 31904





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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |     |  |     |     | Applicable Large Employer Member (Employer)                  |   |                            |      |   |     |     |  |
|---|---------------|---------------------------|-----|--|-----|-----|--|---|----------------------------|------|---|-----|-----|--|
| 1 Name of employee (first name, middle initial, last name)<br>Ashley S Turner |               |                           |     | 2 Social security number (SSN)<br>XXX-XX-1341        |     |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |   |                            |      | 8 Employer identification number (EIN)<br>581942486   |     |     |  |
| 3 Street address (including apartment no.)<br>7003 Stone Ct                   |               |                           |     |  |     |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |   |                            |      | 10 Contact telephone number<br>7065713405             |     |     |  |
| 4 City or town<br>Columbus  |               | 5 State or province<br>GA |     | 6 Country and ZIP or foreign postal code<br>US 31904 |     |     | 11 City or town<br>Columbus                                  |   | 12 State or province<br>GA |      | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |  |
| Part II Employee Offer of Coverage  |               |                           |     | Employee's Age on January 1                          |     |     |  | Plan Start Month (enter 2-digit number): 01 |                            |      |   |     |     |  |
|   | 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   |               |                           |     |  |     |     |  |   |                            |      |   |     |     |  |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|---------|---|--------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |         |   |        |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Ashley  | S | Turner | XXX-XX-1341          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | Jack    |   | Turner | XXX-XX-7953          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   | Guy     |   | Turner | XXX-XX-3457          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21   | Frances |   | Turner | XXX-XX-4608          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 22   | Mildred | 0 | Turner | XXX-XX-8723          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 23   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |         |   |        |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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**

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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Guy Vaiselberg  
7794 GA Hwy 39  
Omaha, GA 31821



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

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

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OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |     |   |     |     |     |
|--|---------------|---------------------------|---|--|--|-----------------------------|---|---|-----|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Guy Vaiselberg |               |                           | 2 Social security number (SSN)<br>XXX-XX-1805 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |     |   |     |     |     |
| 3 Street address (including apartment no.)<br>7794 GA Hwy 39                 |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |     |   |     |     |     |
| 4 City or town<br>Omaha  |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31821 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |     | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage   |               |                           |   | Employee's Age on January 1                          |  |                             |   | Plan Start Month (enter 2-digit number): 01         |     |   |     |     |     |
|  | 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  | 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  |
| 17 ZIP Code  |               |                           |   |  |  |                             |   |   |     |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)



**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                          |                          |                          |                          |                          |
|--|---------|--|------------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |         |  |            |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   | Guy     |  | Vaiselberg | XXX-XX-1805          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   | Jennell |  | Vaiselberg | XXX-XX-6654          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   | Ripley  |  | Rivera     | XXX-XX-2330          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |         |  |            |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Morgan K Whitaker  
148B Epps Court  
Seale, AL 36875



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.

Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|---|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Morgan K Whitaker |               |                           | 2 Social security number (SSN)<br>XXX-XX-2745 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>148B Epps Court                   |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Seale   |               | 5 State or province<br>AL |   | 6 Country and ZIP or foreign postal code<br>US 36875 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|   | 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

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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage              |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |                                     |
|--|--------|---|----------|----------------------|--|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |        |   |          |                      |  |                           | Jan                                 | Feb                                 | Mar                                 | Apr                                 | May                                 | June                                | July                                | Aug                                 | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Morgan | K | Whitaker | XXX-XX-2745          |  | <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 20   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 21   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 22   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 23   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |        |   |          |                      |  | <input type="checkbox"/>  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.



W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Cleveland White  
7337 Standing Boy Rd  
Columbus, GA 31904



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

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

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

**2023**

| Part I Employee   |               |                           |   |  |  |                             | Applicable Large Employer Member (Employer) |   |     |   |     |     |     |
|---|---------------|---------------------------|---|--|--|-----------------------------|---|---|-----|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Cleveland   |               |                           | 2 Social security number (SSN)<br>XXX-XX-2070 |  | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |                             |   | 8 Employer identification number (EIN)<br>581942486 |     |   |     |     |     |
| 3 Street address (including apartment no.)<br>7337 Standing Boy Rd        |               |                           |   |  | 9 Street address (including room or suite no.)<br>PO BOX 140 |                             |   | 10 Contact telephone number<br>7065713405           |     |   |     |     |     |
| 4 City or town<br>Columbus  |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 31904 |  | 11 City or town<br>Columbus |   | 12 State or province<br>GA                          |     | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage  |               |                           |   | Employee's Age on January 1                          |  |                             |   | Plan Start Month (enter 2-digit number): 01         |     |   |     |     |     |
|   | 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   | 1H   | 1H                          | 1H  | 1H  | 1H  | 1H  | 1H  | 1H  | 1H  |
| 15 Employee Required Contribution (see instructions)                      | \$            | \$                        | \$  | \$   | \$   | \$                          | \$  | \$  | \$  | \$  | \$  | \$  | \$  |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) |               |                           |   |  | 2A   | 2A                          | 2A  | 2A  | 2A  | 2A  | 2A  | 2A  | 2A  |
| 17 ZIP Code   |               |                           |   |  |  |                             |   |   |     |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--|--|--|--|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  |  |  |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                     | Oct                      | Nov                      | Dec                      |
| 18   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30   |  |  |  |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**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.

W.C. Bradley Farms, Inc.  
PO BOX 140  
Columbus, GA 31901-140

Justin M White  
4269 GA Hwy 266  
Cuthbert, GA 39840





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

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

☐ VOID

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OMB No. 1545-2251

**2023**

| Part I Employee  |               |                           |   |  |     | Applicable Large Employer Member (Employer)                  |      |   |   |   |     |     |     |
|--|---------------|---------------------------|---|--|-----|--|------|---|---|---|-----|-----|-----|
| 1 Name of employee (first name, middle initial, last name)<br>Justin M White |               |                           | 2 Social security number (SSN)<br>XXX-XX-7390 |  |     | 7 Name of employer<br>W.C. Bradley Farms, Inc.               |      |   | 8 Employer identification number (EIN)<br>581942486 |   |     |     |     |
| 3 Street address (including apartment no.)<br>4269 GA Hwy 266                |               |                           |   |  |     | 9 Street address (including room or suite no.)<br>PO BOX 140 |      |   | 10 Contact telephone number<br>7065713405           |   |     |     |     |
| 4 City or town<br>Cuthbert   |               | 5 State or province<br>GA |   | 6 Country and ZIP or foreign postal code<br>US 39840 |     | 11 City or town<br>Columbus                                  |      | 12 State or province<br>GA                  |   | 13 Country and ZIP or foreign postal code<br>US 31901 |     |     |     |
| Part II Employee Offer of Coverage   |               |                           |   | Employee's Age on January 1                          |     |  |      | Plan Start Month (enter 2-digit number): 01 |   |   |     |     |     |
|  | 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  |               |                           |   |  |     |  |      |   |   |   |     |     |     |

## 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](http://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](http://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).

**1I.** 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.

**1O.** 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)

**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)<br>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 | (e) Months of coverage   |                          |                          |                          |                          |                          |                          |                          |                                     |                                     |                                     |                                     |
|--|--------|---|-------|----------------------|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
|  |        |   |       |                      |  |                           | Jan                      | Feb                      | Mar                      | Apr                      | May                      | June                     | July                     | Aug                      | Sept                                | Oct                                 | Nov                                 | Dec                                 |
| 18   | Justin | M | White | XXX-XX-7390          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19   | Ellie  |   | White | XXX-XX-3662          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20   | Bailey |   | White | XXX-XX-4557          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21   | Amanda |   | White | XXX-XX-3677          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 22   | Nora   | 0 | White | XXX-XX-1813          |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 23   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 24   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 25   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 26   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 27   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 28   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 29   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 30   |        |   |       |                      |  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |

**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.