Kesha Adams 812 NW 3RD ST NEWCASTLE, OK 73065

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OMB No. 1545-2251

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

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

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Part I Emp	loyee						Α	pplicable L	arge Emplo	yer Memb	er (Employ	/er)					
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Em	ployer identifica	tion number (EIN)				
Kesha		Adams	6		XXX-XX-88	371	W.C. Bradl	ley Co.		581605	6660						
3 Street address (in	ncluding apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Cor	10 Contact telephone number					
812 NW 3RD	ST						PO BOX 1	40			7065713405						
4 City or town		5 State or provi	nce	6 Count	6 Country and ZIP or foreign postal code				12 State or pro	ovince	<b>13</b> Cou	13 Country and ZIP or foreign postal coo					
<b>NEWCASTLE</b>					3065		Columbus GA				US 3	31901					
Part II Emp	Part II Employee Offer of Coverage					s Age on c	January 1		Plan Star	<b>t Month</b> (er	nter 2-digit n	digit number): 01					
	All 12 Months Jan Feb Offer of				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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$				
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																	
17 ZIP Code																	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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

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

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

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

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I <b>rt III Cov</b> If En	rered Ind	ividuals ovided self-ins	ured coverage, check th	ne box and enter th	e informati	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name First name	e of covered i e, middle initi	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Kesha		Adams	XXX-XX-8871	,		X	X	X	X	×	X	×	X	X		X	X
19	Dakota	D	Lewis	XXX-XX-5421			$\times$	$\boxtimes$	X	$\times$	X	X	X	X	$\times$	$\times$	X	$\times$
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**Line 17.** This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

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Kenneth G Anderson 2100 Old Guard Rd, Appt 1803 Columbus, GA 31909

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Part I Emp	oloyee						Α	pplicable L	er (Emplo	yer)					
1 Name of employ	ree (first name, r	middle initial, las	st name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Em	nployer identific	ation number (EIN)		
Kenneth		G Ander	son		XXX-XX-35	575	W.C. Bradl	ley Co.				58160	5660		
3 Street address (i	ncluding apartn	nent no.)					9 Street addre	ess (including roo	<b>10</b> Co	10 Contact telephone number					
2100 Old Gua	rd Rd Appt	1803					PO BOX 140					7065713405			
4 City or town		5 State or provi	nce	6 Counti	ry and ZIP or foreig	n postal code	11 City or town	ı	12 State or province			13 Country and ZIP or foreign postal coo			
Columbus					909		Columbus GA				US :	31901			
Part II Emp	oloyee Offe	er of Cover	age		Employee's	s Age on c	January 1		Plan Star	<b>t Month</b> (er	nter 2-digit r	digit number): 01			
	All 12 Months Jan Feb Offer of				Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Mark Andrews 8030 Wellington Trace Midland, GA 31820

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

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OMB No. 1545-2251

2023

Internal Revenue Se	rvice		Go to www	.irs.gov/Foi	rm 1095C for ins	structions an	id the latest i	information.						
Part I Emp	oloyee						Α	pplicable L	er (Emplo	yer)				
1 Name of employ	vee (first name,	middle initial, las	t name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Em	ployer identifica	tion number (EIN)	
Mark		Andre	NS		XXX-XX-5894			ley Co.		581605660				
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ess (including roor	<b>10</b> Co	10 Contact telephone number				
8030 Wellingt	on Trace						PO BOX 1	40			7065713405			
4 City or town		5 State or provi	nce	6 Count	try and ZIP or foreig	n postal code	11 City or town		12 State or province			13 Country and ZIP or foreign postal coo		
Midland		GA		US 3	1820		Columbus		GA		US :	US 31901		
Part II Emp	oloyee Off	er of Cover	age		Employee's	s Age on J	January 1		Plan Star	t <b>Month</b> (e	nter 2-digit r	digit number): 0		
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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	art III Co	overed Ind Employer pro	<b>ividuals</b> ovided self-insu	red coverage, check th	ne box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> Nai First na	me of covered into	ndividual(s) al. last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

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

Valerie Anonyuo 1291 Front Avenue, Suite 201 Columbus, GA 31901

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OMB No. 1545-2251

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

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

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Part I Emp	loyee						А	pplicable L	arge Emplo	yer Memb	er (Employ				
1 Name of employ	ee (first name, r	middle initial, las	t name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Em	ployer identifica	tion number (EIN)		
Valerie		Anony	uo		XXX-XX-01	55	W.C. Bradl	ley Co.				581605	6660		
3 Street address (in	ncluding apartm	nent no.)		•			9 Street addre	ess (including roc	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
1291 Front Av	enue Suite	201					PO BOX 1	40				7065713405			
4 City or town	į	5 State or provin	nce	6 Count	ry and ZIP or foreig	n postal code	11 City or town	ı	12 State or pro	ovince	<b>13</b> Cou	13 Country and ZIP or foreign postal coo			
Columbus							Columbus		GA		US 3	31901			
Part II Emp	Part II Employee Offer of Coverage					s Age on c	January 1		Plan Star	<b>t Month</b> (er	nter 2-digit n	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

Pa	I <b>rt III Cove</b> If Em	ered Individ ployer provide	<b>uals</b> ed self-insure	ed coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name First name,	of covered individual, middle initial, las	dual(s) st name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Jayasankar Arla 10410 Doherty Spring San Antonio, TX 78255

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Depar						,

VOID OMB No. 1545-2251

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

Internal Revenue Ser	rvice		Go to ww	w.irs.gov/For	<i>m10</i> 95C for in	structions a	nd the latest in	nformation.					<u></u>		
Part I Emp	oloyee						A	pplicable L	arge Empl	oyer Memb	er (Em	ployer	)		
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer				8 Employ	er identifica	tion number (EIN)	
Jayasankar		Arla			XXX-XX-16	530	W.C. Bradl	ley Co.					581605	660	
3 Street address (in	ncluding apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		1	10 Contact telephone number			
10410 Dohert	y Spring						PO BOX 140				7065713405				
4 City or town	5	State or provi	nce	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or province			13 Country	and ZIP or f	oreign postal code	
San Antonio	7	ГХ		US 78	3255		Columbus		GA			US 319	01		
Part II Emp	oloyee Offe	r of Cover	age		Employee <sup>2</sup>	s Age on	January 1		Plan Star	rt Month (er	nter 2-di	igit num	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	00	ct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1,	A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code				a a anavata i					N- 00705M					1005 C (2000	

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

Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Robert Bagby 905 E Quinton Street Broken Arrow, OK 74011

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Depar	tment	of the Tr	easury
Intern	al Revi	enue Ser	vice

OMB No. 1545-2251

VOID

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

Internal Revenue Se	ervice		Go to www	/.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	itormation.					
Part I Emp	ployee						Aı	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, r	middle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)
Robert		Bagb	У		XXX-XX-9	505	W.C. Bradle	ey Co.				581605	6660
3 Street address (	including apartm	nent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	ontact telephone	number
905 E Quinto	n Street					PO BOX 140				706571	3405		
4 City or town	į	5 State or prov	rince	6 Count	6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Co	ountry and ZIP or	foreign postal code
Broken Arrow	,	OK		US 74	1011		Columbus		GA		US	31901	
Part II Emp	ployee Offe	er of Cove	rage		Employee	January 1		Plan Sta	rt Month (e	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			A SI NO III SI										1005 C assess

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa	art III	Covere If Employ	d Indi yer pro	<b>viduals</b> vided self-insu	red coverage, check th	ne box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	e. X		
	(a) First	Name of co	overed in	ndividual(s) ıl, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	1	F-1-	N4	A		Months			Sept	0-4	Nan	D
18	Rober		laic iiille	Bagby	XXX-XX-9605	THV IS NOT EVENIUSING		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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

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

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

Christopher Ball 3636 Richmond St Jacksonville, FL 32205

OMB No. 1545-2251

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Depar						,

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

VOID

Internal Revenue Se	ervice		GO TO WW	w.irs.gov/For	m 1095C for in	1095C for instructions and the latest information.								
Part I Emp	ployee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	8 Employer identification number (EIN)		
Christopher		Ball			XXX-XX-43	358	W.C. Brad	ley Co.				581605660		
3 Street address (i	including apartr	ment no.)			9 Street address (including room or suite no.)						<b>10</b> Co	ntact telephone	number	
3636 Richmon	nd St						PO BOX 1	40				706571	3405	
4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province			ovince	<b>13</b> Coo	untry and ZIP or f	oreign postal code								
Jacksonville		FL		US 32	2205		Columbus GA				US :	US 31901		
Part II Employee Offer of Coverage Employee's Age				's Age on c	January 1		Plan Star	<b>t Month</b> (en	ter 2-digit n	iumber):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

30

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Christopher Ball XXX-XX-4358  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Elizabeth Kohler Ball XXX-XX-1884  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|R Susanna Ball XXX-XX-3613 X |X||X||X| $\times$ |X||X|X |X||X||X||X|Phebe 21 Ball XXX-XX-0038 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

Theresa Bargy 2404 W Beach Drive Panama City, FL 32401

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Intern	al Roy	ם ווחם	Sarvio	20

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

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VOID

OMB No. 1545-2251

Department of the Treasury

Separation of the Treasury

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

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2023

	internal Revenue Se	ervice		GO to www	v.ii s.gov/roi	11110930 101 11	isti uctions ai	iu tile latest li	mormation.						
Theresa Bargy XXX-XX-0465 W.C. Bradley Co. 581605666  3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone num 2404 W Beach Drive PO BOX 140 706571340  4 City or town 5 State or province Panama City FL US 32401 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):  14 Offer of Coverage (enter required code) 1A	Part I Emp	ployee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
3 Street address (including apartment no.) 2404 W Beach Drive  4 City or town Panama City Part II Employee Offer of Coverage    All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov     14 Offer of Coverage (enter equired code)   1A   1A   1A   1A   1A   1A   1A   1	1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
2404 W Beach Drive  4 City or town Panama City Part II Employee Offer of Coverage    All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov	Theresa		Bargy	•		XXX-XX-0	465	W.C. Bradl	ley Co.				581605660		
4 City or town Panama City FL US 32401 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1  All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov Coverage (enter required code)  13 Country and ZIP or foreign postal code US 31901  Plan Start Month (enter 2-digit number):  14 Offer of Coverage (enter required code)  15 Employee Required Contribution (see Contribution (see Instructions)  16 Country and ZIP or foreign postal code US 31901  17 Columbus GA US 31901  Plan Start Month (enter 2-digit number):  18 Country and ZIP or foreign postal code GA  19 Columbus GA  Plan Start Month (enter 2-digit number):  19 Aug Sept Oct Nov  10 Aug Sept Oct Nov  10 Aug Sept Oct Nov  11 Aug Sept Oct Nov  12 State or province GA  13 Country and ZIP or foreign postal code GA  14 Offer of Columbus  15 Employee Required Code Sept Oct Nov  16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	3 Street address (i	including apartm	nent no.)		'			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
Panama City FL US 32401 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):  All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	2404 W Beac	h Drive						PO BOX 1	40				706571	3405	
Part II Employee Offer of Coverage	4 City or town	5	State or prov	ince	6 Counti	ry and ZIP or forei	ign postal code	11 City or town	11 City or town 12 State or province			<b>13</b> Co	ountry and ZIP or	foreign postal code	
All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	Panama City		FL		US 32	2401		Columbus GA			US	US 31901			
14 Offer of Coverage (enter required code)  1A 1	Part II Emp	ployee Offe	r of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01	
Coverage (enter required code)  1A 1		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Required Contribution (see instructions) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Coverage (enter		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
Safe Harbor and Other Relief (enter code, if applicable)	Required Contribution (see	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
17 ZIP Code	Safe Harbor and Other Relief (enter														
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

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

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

CORRECTED

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OMB No. 1545-2251

Department of the Treasury
Internal Revenue Service

Go to w

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

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

Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Jean-Boris Barou XXX-XX-1281 581605660 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number **PO BOX 140** 7065713405 206 plum court 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Columbus US 31909 Columbus GA US 31901 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1A 1A required code) 1A 1A 1A 1A 1A 1A 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

**CORRECTED** 

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OMB No. 1545-2251

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2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Heatherly Born XXX-XX-2316 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 3525 NE 162nd Street **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Lake Forest Park WA US 98155 Columbus GA 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 Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1G required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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#### Instructions for Recipient (continued)

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

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

Mark Bradford 7448 Rolling Bend Court Columbus, GA 31904

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Interna	al Reve	nue Ser	vice

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		Go to www	ırs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	itormation.								
Part I Emp	oloyee						Aı	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)				
1 Name of employ	/ee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer	<b>8</b> Er	nployer identific	ation number (EIN)					
Mark		Bradfo	ord		XXX-XX-93	364	W.C. Bradle	W.C. Bradley Co.					581605660			
3 Street address (i	including apartn	nent no.)		•			9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number				
7448 Rolling I	Bend Court						PO BOX 14	10				7065713405				
4 City or town 5 State or province					6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code			
Columbus GA					904	Columbus		GA		US	US 31901					
Part II Emp	oloyee Offe	er of Cove	rage	,	Employee <sup>2</sup>	s Age on c	January 1		Plan Star	rt Month (e	nter 2-digit ı	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			AdMirina										1005 0 2000			

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered TIN is not available) First name, middle initial, last name all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X  $\times$  $\times$ |X|Bradford XXX-XX-9364 18 Mark  $\times$ X X |X| $|\times|$ |X|X  $|\times|$ |X||X|19 MARY С **BRADFORD** XXX-XX-9560  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X| $\times$  $|\times|$ MARY Κ **BRADFORD** XXX-XX-5802  $\times$ |X||X||X| $\times$ |X||X|X |X||X||X||X|21 **ANNA** С **BRADFORD** XXX-XX-5803  $\times$  $\times$  $\times$  $\times$ X |X||X| $\times$ |X|22 **MARK** С **BRADFORD** XXX-XX-6401 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

John C Bray 2739 Cora Drive Columbus, GA 31906

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

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

VOID

OMB No. 1545-2251

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

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

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Internal Revenue Se	ervice	Go to www.irs.gov/Form1095C for instructions and the latest information.													
Part I Em	ployee						Α	pplicable I	arge Emp	loyer Memb	er (Emplo	yer)			
1 Name of employ	yee (first name, ı	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Ei	8 Employer identification number (EIN)			
John		C Bray			XXX-XX-1	277	W.C. Brad	ley Co.				581605660			
3 Street address (	including apartn			<u>'</u>			9 Street addre	ess (including roo	om or suite no.)		<b>10</b> C	10 Contact telephone number			
2739 Cora Dr	ive					PO BOX 1	40				7065713405				
4 City or town	4 City or town 5 State or province					ign postal code	11 City or town	ı	12 State or	province	<b>13</b> Cd	13 Country and ZIP or foreign postal code			
Columbus GA			US 31	1906	Columbus		GA		US	US 31901					
Part II Em	ployee Offe	er of Cove	rage	•	<b>Employee</b>	's Age on	January 1		Plan Sta	art Month (e	nter 2-digit	-digit number): C			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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Cat. No. 60705M

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	enrolle				employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	 (e) Months of cover May June July			Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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

William Brown 340 Pineland Drive NW Atlanta, GA 30342

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

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

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	nformation.					
Part I Emp	loyee						A	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, i	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)
William		Brown	า		XXX-XX-68	356	W.C. Bradle	ey Co.		581605660			
3 Street address (in	ncluding apartn	nent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number
340 Pineland	Drive NW						PO BOX 14	40				706571	3405
4 City or town		5 State or prov	ince	6 Counti	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code
Atlanta		GA		US 30	342		Columbus		GA		US	31901	
Part II Emp	loyee Offe	er of Cove	rage	·	Employee <sup>3</sup>	's Age on c	January 1		Plan Sta	<b>rt Month</b> (er	nter 2-digit ı	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code									No. 60705M				1095-C (2023)

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

Cat. No. 60705M

## **Instructions for Recipient**

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



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#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered TIN is not available) First name, middle initial, last name all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|18 William XXX-XX-6856 **Brown**  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Elizabeth D Brown XXX-XX-7272  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Madison Κ Brown XXX-XX-5698 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Alice G Brown XXX-XX-4610  $\times$  $\times$  $\times$  $\times$ X |X|X |X|X |X|22 Edward M Brown XXX-XX-8627 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

Anthony Buchholz 14085 W Honey Lane Ct New Berlin, WI 53151

Form	10	<b>95</b> -	·U
Depart	ment c	of the Tre	asury
Intouna	I Davis	nua Can	

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

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3 Street address (including apartment no.)  14085 W Honey Lane Ct  4 City or town  New Berlin  Part II Employee Offer of Coverage  All 12 Months  Jan  Feb  Mar  Apr  4 Offer of Coverage (enter										Ар	plicable L	arge Emplo	yer Membe	er (E	mploye	er)		
1 Name of employ	ee (first name,	middle	initial, last	name)		2 Social	securit	y number	(SSN)	7	Name of emple	oyer				8 Employer identification number (EIN)		
Anthony			Buchho	olz			XXX-	-XX-40	92	W	V.C. Bradle	y Co.				581605660		
3 Street address (	including apartr	ment n	0.)							9 Street address (including room or suite no.)						10 Contact telephone number		
14085 W Hon	ney Lane C	t								PO BOX 140						7065713	405	
4 City or town		5 Stat	e or provin	ice		6 Country	and ZII	P or foreig	n postal code	11	City or town		12 State or pr	ovince		13 Coun	itry and ZIP or fo	reign postal code
New Berlin						US 53151				lс	Columbus		GA			US 31	1901	
							Emp	loyee's	s Age on .	Ja	nuary 1		Plan Star	t Month (en	ter 2-	digit nu	ımber):	01
	All 12 Months	5	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)	\$	\$		\$	\$		\$		\$	9	\$	\$	\$	\$	\$		\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																		
17 ZIP Code																		

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

Cat. No. 60705M

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|**Buchholz** XXX-XX-4092 18 Anthony  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 myleigh buchholz XXX-XX-4444  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|Makayla Buchholz XXX-XX-1776 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Serena **Buchholz** XXX-XX-5561  $\times$ X  $\times$  $\times$  $\times$  $\times$ X |X|X |X|22 Mia Buchholz XXX-XX-9188 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

Guy Byll 15 8th Steet Columbus, GA 31901

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

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www.	.irs.gov/Fo	<i>rm10</i> 95C for in	structions ar	nd the latest in	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Soci	al security numbe	er (SSN)	7 Name of emp	oloyer			8 En	nployer identifica	tion number (EIN)	
Guy		Byll			XXX-XX-6	771	W.C. Bradl	ey Co.		581605660				
3 Street address (i	including apart	ment no.)		<u>'</u>			9 Street addres	ss (including roc	m or suite no.)		<b>10</b> Co	10 Contact telephone number		
15 8th Steet							PO BOX 14	40				706571	3405	
4 City or town		5 State or prov	vince	6 Count	try and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	oreign postal code	
Columbus GA US 31901							Columbus		GA		US	31901		
Part II Employee Offer of Coverage Employee's Age of							January 1		Plan Sta	<b>rt Month</b> (er	nter 2-digit r	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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Byll 18 XXX-XX-6771 Guy  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$  $\times$ 19 AVA **BYLL** XXX-XX-9446  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|20 ZOE **BYLL** XXX-XX-1316 X |X||X||X| $\times$ |X||X|X |X||X||X||X|HEATHER ALDAY-BYLL XXX-XX-9651 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Yaniree J Carvajal 11433 NW 51 Lane Doral, FL 33178

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

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		GO to www	i.irs.gov/Fori	m 1095C for in	structions ar	ia tne latest in	itormation.						
Part I Emp	ployee						A	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	8 Employer identification number (EIN)		
Yaniree		J Carva	jal		XXX-XX-59	928	W.C. Bradle	ey Co.		581605660				
3 Street address (i	including apartn	nent no.)	-				9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number	
11433 NW 51	Lane						PO BOX 14	40				706571	3405	
4 City or town		5 State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Doral FL US 33178							Columbus		GA		US	31901		
Part II Emp	ployee Offe	er of Cove	rage	•	Employee <sup>3</sup>	s Age on c	lanuary 1		Plan Star	t Month (e	nter 2-digit ı	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													1005.0	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Yaniree XXX-XX-5928 Carvajal  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Julietta Garcia XXX-XX-0578  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|**Jhonny** Garcia XXX-XX-4957 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Garcia XXX-XX-7861 Franco 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

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

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

Alexander ChungYung Chan 802 Broadway Columbus, GA 31901

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Form	IU	<b>95</b>	-U
Depar	tment	of the Tr	easury
Interna	al Reve	nue Ser	vice

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

OMB No. 1545-2251

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

VOID

internal nevertue se	rvice		ao to www	v.ii s.gov/i oi	<i></i>	isti uctionis ai	ia the latest ii	normation.				I	
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emp	loyer)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer			8	Employer identifica	tion number (EIN)
Alexander Ch	ungYung	Chan			XXX-XX-1	159	W.C. Bradl	ey Co.				581605	660
3 Street address (i	including apart	ment no.)					9 Street addres	ss (including roo	m or suite no.)		10	Contact telephone	number
802 Broadway	У						PO BOX 14	40				706571	3405
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	rovince	13	Country and ZIP or t	oreign postal code
Columbus		GA		US 3	1901		Columbus		GA		U:	S 31901	
Part II Emp	oloyee Off	er of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Star	rt Month (er	nter 2-digi	it 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			AdMatter										1005 0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Alexander Ch Chan XXX-XX-1159  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$  $\times$ Chan XXX-XX-3817 19 Ilyas  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Saba Gilani XXX-XX-2214 X |X||X||X| $\times$ |X||X|X |X||X||X||X|Chan XXX-XX-5067 Ayyad 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Udipi Ananth Charya 3548 Myrtlewood Chase NW Kennesaw, GA 30144

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

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

CORRECTED

VOID

OMB No. 1545-2251

DRRECTED 201

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

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Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Empl	loyer)		
1 Name of employe	ee (first name,	middle initial, la	st name)	2 Soci	al security numbe	er (SSN)	7 Name of em	ployer			8	Employer identific	ation number (EIN)	
Udipi		A Charya XXX-XX-1894						ley Co.				58160	5660	
3 Street address (including apartment no.)							9 Street addre	ess (including roo	m or suite no.)		10	10 Contact telephone number		
3548 Myrtlewo	od Chase	NW					PO BOX 1	40				706571	3405	
4 City or town		5 State or prov	rince	6 Coun	try and ZIP or fore	ign postal code	11 City or town	ı	12 State or p	rovince	13 (	Country and ZIP or	foreign postal code	
Kennesaw					0144		Columbus		GA		US	US 31901		
Part II Emp	loyee Off	er of Cove	rage	<u>'</u>	Employee	's Age on	January 1		Plan Star	rt Month (ei	nter 2-digi	-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 a									No. 60705M				n <b>1095-C</b> <i>(</i> 2023	

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Udipi 18 XXX-XX-1894 Α Charya  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 **RAGHAV ACHARYA** XXX-XX-7541  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|**SUDHA KUMARI** XXX-XX-4292 X |X||X||X| $\times$ |X||X|X |X||X||X||X|**ROHAN** 21 **ACHARYA** XXX-XX-6924 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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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

Kimberly A Chewning 12014 Riverhills Dr Tampa, FL 33617

Form	10	95	<b>)</b> -	Ü
Depart	ment o	of the T	Trea:	sury
Intorno	I Dovo	nua C	an da	•

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

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www	v.irs.gov/Fo	<i>rm10</i> 95C for in	nstructions ar	nd the latest in	nformation.					
Part I Em	ployee						Α	pplicable l	arge Emp	loyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Soc	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identifica	ation number (EIN)
Kimberly		A Chew	ning .		XXX-XX-9	234	W.C. Bradl	ley Co.				581605660	
3 Street address (	eet address (including apartment no.)						9 Street addre	ss (including roo	om or suite no.)		<b>10</b> C	ontact telephone	number
12014 Riverh	ills Dr						PO BOX 1	40				706571	3405
4 City or town		5 State or prov	vince	6 Coun	try and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> C	ountry and ZIP or	foreign postal code
Tampa		FL		US 3	3617		Columbus		GA		US	31901	
Part II Em	ployee Off	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	art Month (e	nter 2-digit	number):	01
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17 ZIP Code													1005 0 2222

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Cat. No. 60705M

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#### Instructions for Recipient (continued)

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

Derik Clement 2723 S 114th E Ave Tulsa, OK 74129

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

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

internal Revenue Se	rvice		GO to www	.irs.gov/rori	11110950 101 111	istructions ar	id the latest ii	mormation.						
Part I Emp	oloyee						А	pplicable L	arge Emp	loyer Meml	ber (Emple	oyer)		
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
Derik		Cleme	ent		XXX-XX-2	413	W.C. Bradley Co.					581605660		
3 Street address (i	ncluding apartme	ent no.)		•			9 Street addre	ess (including roo	m or suite no.)		10 0	10 Contact telephone number		
2723 S 114th	E Ave						PO BOX 1	40				706571	3405	
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	ign postal code	11 City or town		12 State or p	orovince	<b>13</b> C	ountry and ZIP or	foreign postal code	
Tulsa		OK		US 74	129		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01	
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Cat. No. 60705M

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- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Name of on First name, mi	covered ii iddle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera  July	ge Aug	Sept	Oct	Nov	Dec
18	Derik		Clement	XXX-XX-2413			$\times$	$\times$	$\times$	$\times$	$\times$	X	X	$\times$	$\times$	$\times$	X	$\times$
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#### Instructions for Recipient (continued)

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

**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

Elizabeth S Cliatt 3234 River Avenue Columbus, GA 31904

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		GO tO WW	/.irs.gov/For	m 1095C for in	structions ar	ia the latest in	itormation.					
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)	
1 Name of employ	vee (first name, i	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)
Elizabeth		S Cliatt			XXX-XX-53	346	W.C. Bradle	ey Co.				581605	6660
3 Street address (i	including apartn	nent no.)					,				<b>10</b> Co	ontact telephone	number
3234 River Avenue						PO BOX 14	40				706571	3405	
4 City or town		5 State or pro	vince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code
Columbus		GA		US 31	904		Columbus		GA		US	31901	
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee'	s Age on	January 1		Plan Star	t Month (e	nter 2-digit ı	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													1005.0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|S Cliatt 18 Elizabeth XXX-XX-5346  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$ X  $|\times|$  $\times$ 19 Phoebe Cliatt XXX-XX-3640  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Wade Cliatt XXX-XX-3168 21 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

Miah K Cliatt 59 Rosemount Circle Phenix City, AL 36869

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

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Part I Emp	ployee							Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle	initial, las	t name)	2 Socia	I security number	er (SSN)	7 Name of emp	ployer				8 Emp	loyer identificat	tion number (EIN)		
Miah		Κ	Cliatt			XXX-XX-4	780	W.C. Bradley Co.						581605660			
3 Street address (i	including apartı	ment n	o.)					9 Street addre	ss (including roor	n or suite no.)		1	10 Contact telephone number				
59 Rosemount Circle								PO BOX 1	40		7065713405						
4 City or town		5 Stat	e or provir	nce	6 Countr	6 Country and ZIP or foreign postal code 1				12 State or pr	ovince	1	13 Country and ZIP or foreign postal code				
Phenix City						869		Columbus		GA		Į (	US 31901				
Part II Employee Offer of Coverage						<b>Employee</b>	's Age on .	January 1		Plan Star	<b>t Month</b> (en	ter 2-di	igit nu	01			
	All 12 Months	3	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	00	ct	Nov	Dec		
14 Offer of Coverage (enter required code)			1H	1H	1H	1H	1H	1H	1H	1A	1A	1,	A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	2A	2A	2A	2D								
17 ZIP Code																	

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

Cat. No. 60705M

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

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Pa	I <b>rt III Cove</b> i If Emp	red Indi loyer pro	<b>viduals</b> vided self-insu	ured coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, r	f covered in	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Miah	K	Cliatt	XXX-XX-4780	,									X	X	X	X	X
19	Marley	J	Cliatt	XXX-XX-3426										$\times$	X	X	X	$\times$
20	Markeith	L	Cliatt	XXX-XX-2429										$\times$	$\times$	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

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

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

Amy Cook 110 Rosewood Court Fortson, GA 31808

OMB No. 1545-2251

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

VOID

Internal Revenue Service Go to www.irs.gov/Form1095C for instruction							ia the latest i	information.							
Part I Emp	ployee						Α	Applicable L	er (Emplo	yer)					
1 Name of employ	ee (first name,	middle initial, I	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	nployer	8 Em	nployer identifica	ation number (EIN)				
Amy		Cook			XXX-XX-8	029	W.C. Brad	lley Co.		581605660					
3 Street address (i	including aparti	ment no.)		•				ess (including roo	<b>10</b> Co	10 Contact telephone number					
110 Rosewoo	d Court						PO BOX 140					7065713405			
4 City or town		5 State or pro	vince	6 Count	6 Country and ZIP or foreign postal code 1			1	12 State or pr	rovince	<b>13</b> Co	13 Country and ZIP or foreign postal code			
Fortson GA					US 31808				GA		US:	31901			
Part II Emp	oloyee Off	er of Cove	erage		Employee	's Age on <b>.</b>	January 1		Plan Star	<b>t Month</b> (en	iter 2-digit r	-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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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

Cat. No. 60705M

## **Instructions for Recipient**

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

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

Pa	I <b>rt III</b> Covere		red coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of of First name, mi		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	) Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Amy	Cook	XXX-XX-8029			×	X	X	X	×	X	×	X	X	$\boxtimes$	×	$\times$
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#### Part III. Covered Individuals, Lines 18–30

Mallory Cosby 31 Maggy Ct Phenix City, AL 36867

Form	1	0	9	5	_	C
Depai	tme	ent o	of th	ne T	rea	sury

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

CORRECTED

VOID

OMB No. 1545-2251

2023

					s.gov/Form1095C for instructions and the latest information.												
Part I Emp	oloyee						Applicable Large Employer Member (Employer)										
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Social	security number	(SSN)	7 Name of emp	loyer	8 Em	ployer identifica	tion number (EIN)						
Mallory		Cosby			XXX-XX-46	(XX-XX-4695 W.C. Bradley Co.						581605660					
3 Street address (i	ncluding aparti	ment no.)					9 Street address	s (including roo	m or suite no.)		<b>10</b> Cor	10 Contact telephone number					
31 Maggy Ct							PO BOX 14	10		7065713405							
4 City or town	City or town 5 State or province 6 Country and ZIP or foreign postal of						11 City or town 12 State or province					13 Country and ZIP or foreign postal cod					
Phenix City AL					US 36867				GA		US 3	US 31901					
Part II Emp	oloyee Off	er of Cover	age		Employee's	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit n	-digit number):					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
<b>14</b> Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H				
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$				
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A				
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Cat. No. 60705M

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Pa	Irt III Cove	ered Individual ployer provid	duals ded self-insure	ed coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name First name,	of covered indiv	ridual(s) ast name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Mallory		Cosby	XXX-XX-4695	,		X								ССРІ			
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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Christopher Cruz 1037 Chippendale Trail SW Marietta, GA 30064

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

VOID CORRECTED

OMB No. 1545-2251

2023

Internal Revenue Ser	rvice		Go to www	.irs.gov/Forn	nov/Form1095C for instructions and the latest information.							4		
Part I Emp	loyee						Α	oplicable L	arge Emplo	yer Memb	er (Employ	/er)		
1 Name of employ	ee (first name, i	middle initial, las	t name)	2 Social	security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identific	ation number (EIN)	
Christopher		Cruz			XXX-XX-86	58	W.C. Bradl	ey Co.				581605660		
3 Street address (including apartment no.)					9 Street addres	ss (including roc	m or suite no.)		<b>10</b> Co	ntact telephone	number			
1037 Chippen	dale Trail S	SW					PO BOX 14	10				706571	3405	
4 City or town	,	5 State or proving	nce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pr	ovince	<b>13</b> Cou	intry and ZIP or	foreign postal code	
Marietta		GA		US 30	064		Columbus		GA		US 3	31901		
Part II Emp	loyee Offe	er of Cover	age		Employee's	s Age on c	January 1		Plan Star	<b>t Month</b> (en	iter 2-digit n	umber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (e) Months of coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ |X|Christopher Cruz XXX-XX-8658  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ |X|ALLISON CRUZ XXX-XX-9326 19 S 20 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

Wendy Derricotte 2668 Dalewood Dr Columbus, GA 31907

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Depar						,

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

CORRECTED

VOID

OMB No. 1545-2251

2023

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

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

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oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emp	oloyer)	
ee (first name, n	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8	Employer identifica	tion number (EIN)
	Derric	otte		XXX-XX-9	513	W.C. Bradley Co.					581605	6660
ncluding apartm	ent no.)					9 Street addre	9 Street address (including room or suite no.)				Contact telephone	number
od Dr						PO BOX 1	40				706571	3405
5	State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13	Country and ZIP or	oreign postal code
	GA		US 31	1907		Columbus		GA		U	S 31901	
oloyee Offe	r of Cove	rage	•	Employee <sup>3</sup>	's Age on	January 1		Plan Star	<b>t Month</b> (er	nter 2-dig	jit number):	01
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	. 1A	1A
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
												1095-C (2023)
	ee (first name, not of Dr	ployee ee (first name, middle initial, la	bloyee ee (first name, middle initial, last name) Derricotte Including apartment no.) Dod Dr  5 State or province GA  bloyee Offer of Coverage All 12 Months Jan Feb  1A 1A  \$ \$ \$	ployee ee (first name, middle initial, last name)   Derricotte     Derricotte	ployee ee (first name, middle initial, last name)  Derricotte  XXX-XX-9! Including apartment no.)  Dod Dr  S State or province  GA  US 31907  Ployee Offer of Coverage  All 12 Months  Jan  Feb  Mar  Apr	ployee ee (first name, middle initial, last name)	Policy Per ee (first name, middle initial, last name) Pee (first name, middle initial, last name) Derricotte    Derricotte   XXX-XX-9513   W.C. Brade	Applicable Lee (first name, middle initial, last name)  ee (first name, middle initial, last name)  Derricotte    Derricotte	Applicable Large Employee  dee (first name, middle initial, last name)  Detricotte  XXX-XX-9513  XXX-XX-9513  Columbus  Applicable Large Employer  W.C. Bradley Co.  9 Street address (including room or suite no.)  PO BOX 140  5 State or province  GA  US 31907  Columbus  GA  All 12 Months  Jan  Feb  Mar  Apr  May  June  July  Aug  1A  1A  1A  1A  1A  1A  1A  1A  1A  1	Applicable Large Employer Memb ee (first name, middle initial, last name) Derricotte    Derricotte   XXX-XX-9513   7 Name of employer   W.C. Bradley Co.	Applicable Large Employer Member (Employer   Manual Employer   M	Applicable Large Employer Member (Employer)  ee (first name, middle initial, last name) Derricotte    Derricotte   Derrico

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
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- 1Y. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (e) Months of coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN First name, middle initial, last name TIN is not available) all 12 months Aug Jan Feb Mar Apr May June July Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ |X| $|\times|$ 18 XXX-XX-9513 Wendy Derricotte  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ |X|XXX-XX-5670 19 Damian Ε Brown 20 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

Kelsy Dillard 5001 Riverchase Dr, Apt 117 Phenix City, AL 36867

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Form	I UJJ-	U
Depart	ment of the Tre	asury
Interna	I Revenue Serv	ice ·

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

CORRECTED

VOID

OMB No. 1545-2251

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

ternal Revenue Service

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

RRECTED 2023

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	nformation.						
Part I Employee						Applicable Large Employer Member (Empl					yer)			
1 Name of employ	/ee (first name, i	niddle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identifica	tion number (EIN)	
Kelsy		Dillard	d		XXX-XX-2	903	W.C. Bradl	ey Co.				581605660		
3 Street address (i	including apartn	cluding apartment no.)					9 Street address	ss (including roc	m or suite no.)		<b>10</b> Co	ntact telephone	number	
5001 Riverchase Dr Apt 117					PO BOX 14	40				706571	3405			
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	<b>11</b> City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	oreign postal code	
Phenix City		AL		US 36	5867		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	er of Cove	rage		Employee <sup>3</sup>	s Age on J	January 1		Plan Sta	rt Month (er	nter 2-digit r	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

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- 1Z. Reserved for future use.

Pa	rt III Cover		l coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
		covered individua	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Kelsy	Dilla	XXX-XX-2903			X						Guly	Aug	Серг			
	Remy	Mar	XXX-XX-4208			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

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

Courtney Ellis 2856 Roswell Lane Columbus, GA 31906

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		f the Tre	

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (En	nploye	er)			
1 Name of employ	ee (first name	, middle initial, la	st name)	2 Socia	al security number	r (SSN)	7 Name of emp	ployer				8 Empl	oyer identifica	tion number (EIN)		
Courtney		Ellis			XXX-XX-49	951	W.C. Bradl	ey Co.				581605660				
3 Street address (i	including apar	tment no.)		•			9 Street addre	ss (including roo	m or suite no.)			10 Contact telephone number				
2856 Roswell	Lane				PO BOX 1	40					7065713405					
4 City or town	4 City or town 5 State or province					gn postal code	11 City or town		12 State or pr	ovince		13 Count	try and ZIP or f	oreign postal code		
Columbus	Columbus GA						Columbus		GA		US 31901					
Part II Emp	oloyee Of	fer of Cove	rage		Employee'	s Age on	January 1		Plan Star	<b>t Month</b> (er	nter 2-d	ligit nu	mber):	01		
	All 12 Month	ıs Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	)ct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1	Α	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code									No. 60705M					1095-C (2022		

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

Cat. No. 60705M

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30

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Ellis XXX-XX-4951 18 Courtney  $\times$  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ 19 **STEVEN** M ELLIS XXX-XX-1278  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|**ELLIS STEVEN** M XXX-XX-2838 X |X||X||X| $\times$ |X||X|X |X||X||X||X|**ELLIS** 21 **AVERY** XXX-XX-8616 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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Elizabeth Foster 2122 21st Street Columbus, GA 31906

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Depar	tme	ent (	of th	ne T	rea	sury

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

**CORRECTED** 

VOID

OMB No. 1545-2251 2023

Internal Revenue Service

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

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

Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Elizabeth Foster XXX-XX-8384 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number **PO BOX 140** 7065713405 2122 21st Street 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code US 31906 Columbus GA Columbus GA US 31901 **Employee Offer of Coverage** Employee's Age on January 1 Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1G required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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	(a) Name of of First name, mid		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)									ge Aug	g Sept Oct Nov [					
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Donald Freeman PO Box 1122 Jenks, OK 74037

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)				
1 Name of employ	ree (first name, i	middle initial, la	ıst name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 E	8 Employer identification number (EIN)				
Donald		Freen	nan		XXX-XX-8	893	W.C. Brad	ley Co.		581605660						
3 Street address (i	ncluding apartn	nent no.)		<u>'</u>			9 Street addre	ess (including roc	om or suite no.)		<b>10</b> C	10 Contact telephone number				
PO Box 1122							PO BOX 1	40				7065713405				
4 City or town		5 State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town 12 State or provi			province	<b>13</b> C	ountry and ZIP or	foreign postal code			
Jenks					4037		Columbus		GA		US	US 31901				
Part II Employee Offer of Coverage					Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
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17 ZIP Code			Act Nation of						N- COZOGNA				- 1005 C (2000			

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

Pa	Irt III Covere If Employ			d coverage, check th	e box and enter th	e informatio	on for e	ach inc	dividual	enrolle	d in cov	/erage,	includir	ng the e	employe	ee. 🗵	]	
	(a) Name of co	overed in	idividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
	r ii st riame, mic		i, last riame		The is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Donald		Freeman	XXX-XX-8893			$\times$	$\boxtimes$	$  \times  $	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\boxtimes$
19	KAYE		FREEMAN	XXX-XX-5826			$\times$		$\times$	$\boxtimes$	$\times$							
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#### Instructions for Recipient (continued)

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

**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

Kevin Futo 500 Rocky Shoals Drive Midland, GA 31820

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Form	IU	<b>195</b>	<b>-</b> U
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# **Employer-Provided Health Insurance Offer and Coverage**

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable l	arge Empl	oyer Memb	er (Empl	oyer)		
1 Name of employ	ee (first name,	middle initial,	last name)	<b>2</b> Soc	cial security num	nber (SSN)	7 Name of em	ployer			8 E	mployer identif	fication number (EIN)	
Kevin		Futo	)		XXX-XX-	-6887	W.C. Bradley Co.					581605660		
3 Street address (i	ncluding aparti	ment no.)		•			9 Street addre	ess (including roo	om or suite no.)		<b>10</b> C	ontact telepho	ne number	
500 Rocky Sh	oals Drive						PO BOX 1	40				70657	713405	
4 City or town					oreign postal code	11 City or town	ı	12 State or p	rovince	<b>13</b> C	ountry and ZIP	or foreign postal code		
Midland					31820		Columbus		GA		US	31901		
Part II Emp	oloyee Off	er of Cov	erage	•	Employe	e's Age on	January 1		Plan Sta	rt Month (e	nter 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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005.0	
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|18 Futo XXX-XX-6887 Kevin  $\times$  $\times$ X |X| $|\times|$ |X||X|X  $|\times|$ |X||X|19 **DELANEY** FUTO XXX-XX-2290 Μ  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|FUTO **AMELIA** Κ XXX-XX-8016 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Eli Futo XXX-XX-1279 M  $\times$  $\times$  $\times$  $\times$ X |X|X |X| $\times$ |X|**AMANDA** Κ FUTO XXX-XX-0570 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Teresa W Gillenwaters 1600 54th Street Valley, AL 36854

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

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OMB No. 1545-2251

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be partment of the Treasury sternal Revenue Service Do not attach to your tax return. Keep for your records.

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

internal Revenue Sei	rvice		GO LO WWW	.ii s.gov/roi	11110930 101 111	Structions ar	iu tile latest il	normation.				1 -		
Part I Emp	loyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 Er	8 Employer identification number (EIN)		
Teresa		W Giller	waters		XXX-XX-80	049	W.C. Bradle	ey Co.				581605660		
3 Street address (in	ncluding aparti	ment no.)		'			9 Street address (including room or suite no.)				<b>10</b> Cd	ontact telephone	number	
1600 54th Stre	eet						PO BOX 14	10				706571	3405	
4 City or town		5 State or pro	vince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	<b>13</b> Co	untry and ZIP or	oreign postal code	
Valley		AL		US 36	854		Columbus GA				US	US 31901		
Part II Emp	loyee Off	er of Cove	rage	•	Employee'	s Age on c	January 1		Plan Star	<b>t Month</b> (en	ter 2-digit ı	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 a									No. 60705M				1095-C (2023	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

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

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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Aug Jan Feb Mar Apr May June July Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ W XXX-XX-8049 18 Teresa Gillenwaters 19 20 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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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

Terra Hardwick 1503 Melanie Lane Phenix City, AL 36867

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

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OMB No. 1545-2251

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loyee						Applicable Large Employer Member (Employer)						
ee (first name,	middle initial, la	ast name)	2 Socia	I security numb	er (SSN)	7 Name of employer 8 Employer identification				tion number (EIN)		
	Hard	wick		XXX-XX-2	569	W.C. Bradle	ey Co.				581605	660
ncluding apartr	ment no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ntact telephone	number
Lane						PO BOX 14	10				7065713	3405
	5 State or prov	vince	6 Counti	y and ZIP or fore	eign postal code	11 City or town		12 State or pr	ovince	<b>13</b> Cou	intry and ZIP or f	oreign postal code
	AL		US 36	867		Columbus		GA		US 3	31901	
loyee Off	er of Cove	rage		Employee	's Age on J	lanuary 1		Plan Star	<b>t Month</b> (en	ter 2-digit n	umber):	01
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
r	loyee ee (first name, noluding aparti Lane	bloyee se (first name, middle initial, la Hardy noluding apartment no.)  Lane  5 State or provide AL  bloyee Offer of Cove  All 12 Months Jan	bloyee be (first name, middle initial, last name) Hardwick Including apartment no.) Lane  5 State or province AL  Bloyee Offer of Coverage All 12 Months Jan Feb		bloyee se (first name, middle initial, last name)  Hardwick  XXX-XX-2 Including apartment no.)  Lane  5 State or province AL US 36867  Iloyee Offer of Coverage  All 12 Months Jan Feb Mar Apr	loyee se (first name, middle initial, last name) Solution apartment no.)  Lane  5 State or province AL US 36867  All 12 Months Jan Feb Mar Apr May	loyee se (first name, middle initial, last name) Hardwick  Lane  5 State or province AL  US 36867  Sloyee Offer of Coverage  All 12 Months  All 12 Months  All 12 Months  All 12 Months  All (first name, middle initial, last name) All (first name, middle initial, last name) All 2 Social security number (SSN) AXX-XX-2569  W.C. Bradle W.C. Bradle All 2 Social security number (SSN) AXX-XX-2569  W.C. Bradle All 2 Social security number (SSN) AXX-XX-2569  US 36867  Feb Mar Apr May June	Applicable Lee (first name, middle initial, last name)  Pee (first name, middle initial, last name)  Hardwick  XXX-XX-2569  Cludding apartment no.)  Lane  5 State or province AL  US 36867  Clumbus  Feb  Mar  Apr  May  Applicable Le  7 Name of employer  W.C. Bradley Co.  9 Street address (including roo PO BOX 140  11 City or town Columbus  Loyee Offer of Coverage  Employee's Age on January 1  All 12 Months  Jan  Feb  Mar  Apr  May  June  July	Applicable Large Employer  see (first name, middle initial, last name)  Hardwick  XXX-XX-2569  Cludding apartment no.)  Lane  5 State or province AL  US 36867  Clumbus  All 12 Months  Jan  Feb  Mar  Apr  May  Applicable Large Employe  W.C. Bradley Co.  9 Street address (including room or suite no.)  PO BOX 140  12 State or province Columbus  GA  Plan Star  All 12 Months  Jan  Feb  Mar  Apr  May  June  July  Aug	Applicable Large Employer Members (first name, middle initial, last name)  Per (first name, middle initial, last name)  Per (first name, middle initial, last name)  Part (first name, middle initial, last na	Applicable Large Employer Member (Employer Member (Employ	Applicable Large Employer Member (Employer)  se (first name, middle initial, last name)  Hardwick  XXX-XX-2569  Cludding apartment no.)  Lane  5 State or province AL  US 36867  Columbus  AL  US 36867  Employee's Age on January 1  All 12 Months  Jan  Feb  Mar  Apr  May  Apr  May  Apr  May  Apr  May  Apr  May  Apr  Applicable Large Employer Member (Employer)  8 Employer identificate  8 Employer identificate  9 Street address (including room or suite no.)  10 Contact telephone  7065713  12 State or province 13 Country and ZIP or foreign postal code 11 City or town Columbus  GA  US 31901  Plan Start Month (enter 2-digit number):  All 2 Months Aug  Sept  Oct Nov

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Terra Hardwick XXX-XX-2569  $\times$  $\times$  $\times$ X|X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ 19 D Hardwick XXX-XX-8641 John  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|20 John D Hardwick XXX-XX-6774 X |X||X||X| $\times$ |X||X|X  $\times$ S Loyd XXX-XX-5216 Maegan 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Darla Harp 11522 WEST 64TH STREET Sapulpa, OK 74066

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Intern	al Roy	ם ווחם	Sarvio	20

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

CORRECTED

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OMB No. 1545-2251

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

RRECTED 2023

Internal Revenue Se	ervice		Go to www	.irs.gov/Fo	rm1095C for in	structions ar	d the latest in	nformation.						
Part I Emp	ployee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer			8 En	8 Employer identification number (EIN)		
Darla		Harp			XXX-XX-8	663	W.C. Bradley Co.					581605660		
3 Street address (i	including apartr	ment no.)					9 Street addre	ss (including roc	om or suite no.)		<b>10</b> Co	ntact telephone	number	
11522 WEST	64TH STR	REET					PO BOX 1	40				706571	3405	
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Sapulpa							Columbus		GA		US	31901		
Part II Employee Offer of Coverage Employee's						's Age on .	January 1		Plan Sta	rt Month (er	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005.0	

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

Cat. No. 60705M

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

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

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- 1Y. Reserved for future use.
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Pa		Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of ( First name, mi			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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27																		
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30																		

#### Instructions for Recipient (continued)

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

Werdell Hawk 3601 Southlea Court Columbus, GA 31909

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

OMB No. 1545-2251

VOID

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

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Part I Emp	oloyee							Ap	plicable La	arge Emplo	yer Memb	er (Empl	oye	r)	
1 Name of employ	ee (first name,	middle initial	l, last name)		2 Social	security number	er (SSN)	7 Name of emp	loyer			8	Emplo	yer identification	on number (EIN)
Werdell		Hav	vk			XXX-XX-3	444	W.C. Bradle	ey Co.					5816056	60
3 Street address (i	ncluding apartr	ment no.)						9 Street addres	s (including roon	n or suite no.)		10	Conta	ıct telephone nı	umber
3601 Southlea	a Court							PO BOX 14	.0					70657134	405
4 City or town		5 State or p	rovince		6 Country	and ZIP or fore	ign postal code	11 City or town		12 State or pro	ovince	13 (	13 Country and ZIP or foreign postal code		
Columbus GA US 31909						909		Columbus		GA		US	US 31901		
Part II Employee Offer of Coverage Employee's Age on Ja						January 1		Plan Star	t <b>Month</b> (en	ter 2-digi	t nun	nber):	01		
	All 12 Months	Jan	Feb		Mar	Apr	May	June	July	Aug	Sept	Oct		Nov	Dec
<b>14</b> Offer of Coverage (enter required code)		1A	1A		1A	1A	1A	1A	1A	1A	1A	1A		1A	1A
<b>15</b> Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	97	\$	\$
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
<b>17</b> ZIP Code															
															225 2

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

Cat. No. 60705M

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

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#### Instructions for Recipient (continued)

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

Charlotte Hedrick 1026 Briar Ridge Drive Houston, TX 77057

Form	095-	·C
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Internal Re	evenue Serv	ice

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						А	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)		
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	nployer identific	ation number (EIN)	
Name of employee (first name, middle initial, last name)     Charlotte					XXX-XX-6	116	W.C. Bradl	ley Co.				581605660		
3 Street address (i	ncluding apartn	nent no.)		'			9 Street addre	ess (including roc	m or suite no.)		<b>10</b> Cd	ontact telephone	e number	
1026 Briar Ric	dge Drive						PO BOX 1	40				706571	3405	
4 City or town		5 State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	13 Country and ZIP or foreign postal code		
Houston		TX		US 7	7057	Columbus		GA		US	US 31901			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on c	January 1		Plan Sta	art Month (e	nter 2-digit ı	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 0 200	

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

Cat. No. 60705M

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Form 1095-C (2023) Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered TIN is not available) First name, middle initial, last name all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|Hedrick 18 Charlotte XXX-XX-6116  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Vivian G Hedrick XXX-XX-4235  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|Thomas D Hedrick XXX-XX-3378 X |X||X||X| $\times$ |X||X|X |X||X||X||X|Hayden Η Hedrick XXX-XX-4904  $\times$  $\times$  $\times$  $\times$  $\times$ X X |X|X |X|22 Charles Hedrick XXX-XX-2637 23 24 25 26 27 28 29

30

#### Instructions for Recipient (continued)

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James Hillenbrand 8052 Splendor Way Columbus, GA 31904

OMB No. 1545-2251

Form	1	0	9	5	_	C
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest in	formation.					
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)	
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)
James		Hillen	brand		XXX-XX-75	564	W.C. Bradle	ey Co.				581605	6660
3 Street address (i	including apartn	nent no.)		<u> </u>			9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number
8052 Splendo	or Way						PO BOX 14	10				706571	3405
4 City or town	,	5 State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code
Columbus		GA		US 31	904		Columbus		GA		US	31901	
Part II Emp	oloyee Offe	er of Cove	rage	.	Employee'	s Age on J	January 1		Plan Star	rt Month (er	nter 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									N- 00705M				1005 C (2000)

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

Cat. No. 60705M

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X  $\times$  $\times$ |X|Hillenbrand XXX-XX-7564 18 **James**  $\times$  $\times$ X 19 **PETER** G HILLENBRAN XXX-XX-0195  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X| $|\times|$ HILLENBRAN XXX-XX-1717 KATHRYN Α 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Michael Hiner 13 Wildwood Plantation Lane Cataula, GA 31804

Form	10	<b>95</b> -	·U
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## Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee						A	pplicable L	arge Emplo	yer Memb	er (Er	nploy	er)	
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Social	I security numbe	r (SSN)	7 Name of emp	oloyer				8 Emp	loyer identifica	tion number (EIN)
Michael	.	Hiner			XXX-XX-97	791	W.C. Bradle	ey Co.					581605	660
3 Street address (i	ncluding apartr	nent no.)					9 Street addres	ss (including roo	m or suite no.)			<b>10</b> Con	tact telephone	number
13 Wildwood	Plantation	Lane					PO BOX 14	10					706571	3405
4 City or town		5 State or provi	nce	6 Country	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince		<b>13</b> Cour	ntry and ZIP or f	oreign postal code
Cataula		GA		US 31	804		Columbus		GA			US 3	1901	
Part II Emp	loyee Offe	er of Cover	age		Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-	digit nu	ımber):	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														1005.0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Michael Hiner XXX-XX-9791  $\times$  $\times$  $\times$  $\times$ |X||X| $|\times|$ X 19 LINDSAY **HINER** XXX-XX-6134  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|HINER **BEATRICE** XXX-XX-6398 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Audrey D Hollingsworth 6686 Woodberry Road Columbus, GA 31904

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Sei	vice		GO TO WWW	ı.ırs.gov/Fori	n 1095C for in	structions ar	na the latest in	itormation.					
Part I Emp	loyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	oyer)	
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	ation number (EIN)
Audrey	[	Holling	gsworth		XXX-XX-38	396	W.C. Bradle	ey Co.				581605	6660
3 Street address (in	ncluding apartme	ent no.)		•			9 Street addres	ss (including roo	m or suite no.)		<b>10</b> C	Contact telephone	number
6686 Woodbe	rry Road						PO BOX 14	10				706571	3405
4 City or town	5	State or provi	nce	6 Country	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	<b>13</b> C	ountry and ZIP or	foreign postal code
Columbus		3A		US 31	904		Columbus		GA		US	31901	
Part II Emp	loyee Offe	r of Cover	age	'	Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit	number):	01
<u> </u>	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	
<b>17</b> ZIP Code													1005.0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa	art III Covere If Emplo	d Indi	<b>viduals</b> vided self-insure	d coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of c	overed in	dividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

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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

Derrick K Ikuesan 4311 Horder Ct Snellville, GA 30039

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

VOID

OMB No. 1545-2251

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

nternal Revenue Service Go to www.iis.gov/i offiniosoc for institut										iu t	ine latest iii	1011	mation.											
Part I Employee										Applicable Large Employer Member (Employer)														
1 Name of employ	ee (first name,	middle	initial, la	st name)		2 Socia	l seci	urity numbe	er (SSN)	7	Name of emp	loye	er						8 Emp	loyer	dentificatio	n numbe	r (EIN)	
Derrick		Κ	Ikuesa	an			XX	(X-XX-1	744	W	.C. Bradle	y (	Co.							į	5816056	50		
3 Street address (including apartment no.)								9 Street address (including room or suite no.)								10 Contact telephone number								
4311 Horder (	Horder Ct							PO BOX 140							7065713405									
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign postal coo							ign postal code	11 City or town 12 State or province								13 Coun	try a	nd ZIP or fore	ign posta	l code			
Snellville GA US 3						US 30	039	)		C	olumbus			GA	٨				US 31	190	1			
Part II Emp	oloyee Off	er of	Cove	rage			Em	nployee	's Age on .	Jar	nuary 1			Pla	an Start	Mont	<b>h</b> (ent	er 2	digit number): 01					
	All 12 Months	3	Jan	Feb		Mar		Apr	May		June		July		Aug	Sep	pt		Oct		Nov	Dec	С	
<b>14</b> Offer of Coverage (enter required code)			1H	1H		1H		1H	1H		1H		1A		1A	1/	4		1A		1A	1.4	١	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$	<b>3</b>	\$		\$		\$		\$		\$		\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A		2A		2A	2A		2D													
<b>17</b> ZIP Code																								

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

Cat. No. 60705M

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

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

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

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

Elizabeth Irby 1035 NAWENCH DRIVE Atlanta, GA 30327

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Sel	rvice		GO to www.	iis.gov/roii	11110930 101 111	istructions ar	iu trie latest ii	mormation.				~	
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			<b>8</b> En	nployer identific	ation number (EIN)
Elizabeth		Irby			XXX-XX-9	834	W.C. Brad	ley Co.				58160	5660
3 Street address (i	ncluding apartm	nent no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	ntact telephone	number
1035 NAWEN	ICH DRIVE						PO BOX 1	40				706571	3405
4 City or town	5	State or prov	ince	6 Countr	ry and ZIP or forei	ign postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code
Atlanta	(	GA		US 30	327		Columbus		GA		US	31901	
Part II Emp	oloyee Offe	r of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit r	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
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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			Act Notice and						N- COZOEM				- 1005 C (2000

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Cat. No. 60705M

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Pa	I <b>rt III</b> Covere If Emplo	ed Individuals byer provided self	-insured coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered individual(s) ddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Sarah Irby 1035 Nawench Drive NW Atlanta, GA 30327

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

VOID

OMB No. 1545-2251

nternal Revenue Service Go to www.irs.gov/Form1095C for instruction								nd the latest i	nformation.									
Part I Em	ployee							Α	pplicable L	arge Emplo	yer Memb	er (Emplo	Employer)					
1 Name of employ	yee (first name,	middle initia	al, last nan	ne)	2 Socia	al security number	r (SSN)	7 Name of em	ployer			<b>8</b> Er	nployer identific	ation number (EIN)				
Sarah		Irby	y			XXX-XX-06	518	W.C. Brad	ley Co.				581605660					
3 Street address (	including apartr	ment no.)						9 Street addre	ess (including roo	m or suite no.)	<b>10</b> Co	10 Contact telephone number						
1035 Naweno	1035 Nawench Drive NW							PO BOX 1		7065713405								
4 City or town		5 State or p	orovince		6 Count	try and ZIP or forei	gn postal code	11 City or town	1	12 State or pro	ovince	<b>13</b> Co	13 Country and ZIP or foreign postal cod					
						0327		Columbus		GA		US	JS 31901					
Part II Em	ployee Offe	er of Co	verage	)		Employee'	s Age on .	January 1		Plan Star	<b>t Month</b> (er	nter 2-digit	digit number): 01					
	All 12 Months	Jan	1	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
14 Offer of Coverage (enter required code)		1G	i	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G				
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Cat. No. 60705M

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

Pa		ed Individuals oyer provided self-	insured coverage, check th	e box and enter th	e informati	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
		covered individual(s) niddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	lan	Fab	Mor	Apr	(e) May	Months June	of covera		Sept	Oct	Nev	Doo
18	Sarah	Irby	XXX-XX-0618	THE HOLD AVAILABLE)		Jan	Feb	Mar	Apr		June		Aug	Берг	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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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

Virginia Irby 1930 Colland Dr NW Atlanta, GA 30318

Form	095-	·C
	ent of the Tre	

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

VOID

OMB No. 1545-2251

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

internal Revenue Sei	rvice		GO LO WWW	.ii s.yuv/rui	11110930 101 11	isti uctions ai	iu tile latest li	mormation.					
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	yer)	
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	nployer identific	ation number (EIN)
Virginia		Irby			XXX-XX-2	848	W.C. Bradl	ley Co.				58160	5660
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	ntact telephone	e number
1930 Colland	Dr NW						PO BOX 1	40				706571	3405
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code
Atlanta		GA		US 30	0318		Columbus		GA		US:	31901	
Part II Emp	loyee Offe	r of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	irt Month (e	nter 2-digit r	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			A at Nation										1005 C (2222

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa	Covered If Emplo	ed Individuals byer provided self-inst	ured coverage, check th	ne box and enter th	e information	on for e	each inc	dividual	enrolle					employe	ee. 🗵		-
	(a) Name of	covered individual(s) iddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months						) Months						
_	First name, m	iddie initiai, last name		Tilv is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Virginia	Irby	XXX-XX-2848			$\times$			$\times$		$\times$			$\times$	$\times$	$\times$	
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#### Instructions for Recipient (continued)

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

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

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

Ahmad James 654 moye rd Columbus, GA 31907

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

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www	v.irs.gov/Fo	rm1095C for in	nstructions a	ind the latest i	information.					
Part I Emp	oloyee						A	Applicable I	arge Emp	loyer Memb	er (Emp	loyer)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Soci	al security numb	er (SSN)	7 Name of em	nployer			8	Employer identification	ation number (EIN)
Ahmad		Jame	S		XXX-XX-5	081	W.C. Brad	lley Co.		581605660			
3 Street address (i	including apartr	nent no.)					9 Street addre	ess (including ro	10	10 Contact telephone number			
654 moye rd							PO BOX 1	40				706571	3405
4 City or town	City or town 5 State or province 6 Country and ZIP or foreign postal or							11 City or town 12 State or province				Country and ZIP or	foreign postal code
Columbus	S GA US 31907								GA		U:	S 31901	
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-digi	t 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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													1225.0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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

Pa	Covered Individuals  If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.  (a) Name of covered individual(s)  (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																	
	(a) Name of First name, m	covered ii iddle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera  July	ge Aug	Sept	Oct	Nov	Dec
18	Ahmad		James	XXX-XX-5081			$\times$	$\times$	$\times$	$\times$	$\times$	X	$\times$	$\times$	$\times$	$\times$	X	$\times$
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#### Instructions for Recipient (continued)

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

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

Rebecca Jernigan 68 Barefoot Drive Phenix City, AL 36869

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

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

CORRECTED

VOID

OMB No. 1545-2251

the Treasury

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

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

RRECTED 2023

Internal Revenue Se	ervice		Go to www	ı.ırs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	nformation.					
Part I Emp	ployee						Aı	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)	
1 Name of employ	ee (first name, m	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 Ei	mployer identifica	ation number (EIN)
Rebecca		Jernio	jan		XXX-XX-1	392	W.C. Bradle	ey Co.				581605	6660
3 Street address (i	including apartme	ent no.)		•			9 Street address	ss (including roc	m or suite no.)		<b>10</b> C	ontact telephone	number
68 Barefoot D	Prive						PO BOX 14	40				706571	3405
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign postal country							11 City or town 12 State or province				ountry and ZIP or	foreign postal code
Phenix City AL US 36869							Columbus		GA		US	31901	
Part II Emp	ployee Offe	r of Cove	rage		Employee	s Age on c	January 1		Plan Sta	rt Month (e	nter 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													1005 C assess

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

	n 1095-C (2023)																	Page 3
Pa	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																	
	(a) Name of o	covered in	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other	(d) Covered					(e	) Months	of covera	ge			1	
	First name, mi	iddle initia	II, last name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Rebecca		Jernigan	XXX-XX-1392			$\times$	$\times$	$\times$	$\times$	$\times$	X	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
19	HALEY	E	JERNIGAN	XXX-XX-3508			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$						
20	GERALD	1	JERNIGAN	XXX-XX-3604			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$						
21	OETWIED			70.00.700.000.7														
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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

Christi Johnson 1352 Lakeshore Ln Auburn, AL 36830

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

VOID

OMB No. 1545-2251

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

internal Revenue Se	rvice			GO LO WW	W.11 3	.gov/i oili	1103	oc ioi ilis	structions an	u tile latest ill	onnauc	JII.								
Part I Employee										Applicable Large Employer Member (Employer)										_
1 Name of employ	ee (first name,	middle	initial, las	st name)		2 Social	secu	rity number	(SSN)	7 Name of emp	loyer					8 Emp	8 Employer identification number (EIN)			
Christi			Johnso	on			XXX	X-XX-02	249	W.C. Bradley Co.					581605660					
3 Street address (i	ncluding apartr	ment n	o.)							9 Street addres	s (includir	ng room	or suite no.)			10 Contact telephone number				
1352 Lakeshore Ln										PO BOX 14	.0						7065713405			
4 City or town		5 Stat	e or provir	nce		6 Country	6 Country and ZIP or foreign postal code			11 City or town			12 State or pro	vince		13 Coun	try and	ZIP or fore	eign postal code	
Auburn		AL				US 36830				Columbus			GA			US 3	1901			
Part II Emp	oloyee Off	er of	Cover	age			Em	ployee's	s Age on J	anuary 1			Plan Start	t <b>Month</b> (en	ter 2	-digit nu	mber	·):	01	_
	All 12 Months	;	Jan	an Feb		Mar		Apr	May	June	July		Aug	Sept		Oct	ı	Nov	Dec	
<b>14</b> Offer of Coverage (enter required code)			1A	1A		1A		1A	1A	1A	1,	A	1A	1A		1A		1A	1A	_
<b>15</b> Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$	\$		\$	\$	\$		\$		\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
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Cat. No. 60705M

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#### Instructions for Recipient (continued)

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Ashley Jones 503 Double Churches Road Columbus, GA 31904

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Intern	al Roy	anua San	vice

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Se	rvice		Go to www	urs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.						
Part I Emp	oloyee						Α	yer)						
1 Name of employ	vee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of employer					8 Employer identification number (EIN)		
Ashley		Jones	i		XXX-XX-60	037	W.C. Bradl	ley Co.				581605660		
3 Street address (i	including apartm	ent no.)		•			9 Street addre	ss (including roc	om or suite no.)		<b>10</b> Co	ontact telephone	number	
503 Double C	hurches Ro	ad					PO BOX 1	40				706571	3405	
4 City or town	5	State or prov	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Columbus		GΑ		US 31	904		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	r of Cove	rage		Employee <sup>2</sup>	's Age on c	January 1		Plan Sta	rt Month (e	enter 2-digit r	2-digit number):		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|XXX-XX-6037 18 Ashley Jones  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Robert M XXX-XX-9505 Jones  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Ρ 20 Daniel Jones XXX-XX-7599 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Robert Jones XXX-XX-6343 Μ 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Tonya Jones 56 Twin Oaks Court Fortson, GA 31808

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Form	IU	<i>1</i> 95	<b>-</b> U
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	oyer Memb	per (Emplo	oyer)		
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer	8 E	8 Employer identification number (EIN)				
Tonya		Jones			XXX-XX-5890			ley Co.				581605660		
3 Street address (i	ncluding apartn	nent no.)		<u>'</u>			9 Street addre	ess (including roc	om or suite no.)		<b>10</b> C	ontact telephone	number	
56 Twin Oaks	Court						PO BOX 1	40				706571	3405	
4 City or town		5 State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	<b>13</b> C	ountry and ZIP or	foreign postal code	
Fortson		GA		US 31	US 31808				GA		US	31901		
Part II Emp	oloyee Offe	er of Cove	rage	!	Employee <sup>3</sup>	s Age on	January 1		Plan Sta	rt Month (e	nter 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													1005.0	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa	rt III Cover If Empl		ed coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, m		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Tonya	Jones	XXX-XX-5890	,		X	×	×	X	×	X	×	X	X	X	×	X
	DAVID	JONES	XXX-XX-6718			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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

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

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

Lisbeth Justice 2336 Macedonia Road Tallassee, AL 36078

Form I U U U	Form	<b>095-</b>	·U
Department of the Treasury			

CORRECTED

VOID

OMB No. 1545-2251

2023

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

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

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ee (first name, i	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of employer					8 Employer identification number (EIN)		
	Justic	e		XXX-XX-8	537	W.C. Bradley Co.					581605660		
3 Street address (including apartment no.)						9 Street addres	s (including roo	m or suite no.)		10	Contact telephone	number	
nia Road						PO BOX 14	10				706571	3405	
	5 State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	11 City or town 12 State or province			13	Country and ZIP or	foreign postal code		
	AL		US 36	5078		Columbus GA			U:	S 31901			
loyee Offe	er of Cove	rage		Employee <sup>3</sup>	s Age on c	January 1		Plan Star	lan Start Month (enter 2-digit number):			01	
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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												1095-C (2022)	
	ee (first name, including apartnia Road	ee (first name, middle initial, la Justice notuding apartment no.) nia Road  5 State or proving AL  Sloyee Offer of Cove All 12 Months Jan  1A	bloyee ee (first name, middle initial, last name)  Justice Including apartment no.) Inia Road  5 State or province AL  Bloyee Offer of Coverage  All 12 Months  Jan Feb  1A 1A \$\$	ployee see (first name, middle initial, last name) Soloyee Offer of Coverage All 12 Months  1A 1A 1A 2 Social 2 Social 2 Social 3 Social 4 Social 4 Social 5 State or province AL US 36 Mar  1A 1A 1A	ployee ee (first name, middle initial, last name)    Justice	ployee see (first name, middle initial, last name) Soloyee    Social security number (SSN)	loloyee ee (first name, middle initial, last name)   Justice	Applicable Lee (first name, middle initial, last name)    Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   7 Name of employer   W.C. Bradley Co.     Social security number (SSN)   W.C. Bradley Co.     Social s	Applicable Large Employee  dee (first name, middle initial, last name)  dee (first name, middle initial, last name)  Justice  Discrete address (including room or suite no.)  PO BOX 140  Soloyee Offer of Coverage  All 12 Months  Jan  Feb  Mar  Apr  May  June  July  Aug  1A  1A  1A  1A  1A  1A  1A  1A  1A  1	Applicable Large Employer Members (First name, middle initial, last name)    Justice	Applicable Large Employer Member (Employer   Sand   Sand	Applicable Large Employer Member (Employer)  see (first name, middle initial, last name)  Justice    Justice	

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Fetima Kelly 4506 English Ivy Dr Fortson, GA 31808

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OMB No. 1545-2251

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

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Fetima Kellv XXX-XX-0085 581605660 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 4506 English Ivy Dr **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ US 31808 Fortson Columbus GA US 31901 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

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

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

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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Kelly 18 Fetima XXX-XX-0085  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 **ANDREW** KELLY XXX-XX-1599  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|ALEXANDRIA KELLY XXX-XX-1692 X |X||X||X| $\times$ |X||X|X |X||X||X||X|**ANDREW KELLY** XXX-XX-4162 22 23 24 25 26 27 28 29 30

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Karen Kelly 7243 Standing Boy Road Columbus, GA 31904

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OMB No. 1545-2251

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Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	itormation.							
Part I Employee							Applicable Large Employer Member (Employer)								
1 Name of employ	/ee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			8 Ei	mployer identific	ation number (EIN)		
Karen		Kelly			XXX-XX-70	007	W.C. Bradley Co.					581605660			
3 Street address (including apartment no.)						9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	ontact telephone	number			
7243 Standing	g Boy Road						PO BOX 14	10				706571	3405		
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province				<b>13</b> Co	ountry and ZIP or	foreign postal code		
Columbus		GΑ		US 31	904		Columbus GA			US	US 31901				
Part II Emp	oloyee Offe	r of Cove	rage	·	Employee'	s Age on J	lanuary 1		Plan Star	rt Month (ei	nter 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			Ast Nation on										1005 C (2000)		

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Cat. No. 60705M

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

David King 1380 Joe Wells Road Buena Vista, GA 31803

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OMB No. 1545-2251

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Part I Emp	ployee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name,	middle initial, la	ıst name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer	<b>8</b> Er	8 Employer identification number (EIN)					
David		King			XXX-XX-63	363	W.C. Bradle	ey Co.		581605660					
3 Street address (i	including apartr	nent no.)		'			9 Street addres	ss (including roo	<b>10</b> Co	10 Contact telephone number					
1380 Joe Wel	1380 Joe Wells Road											706571	3405		
4 City or town		5 State or prov	rince	6 Countr	6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Co	ountry and ZIP or	foreign postal code		
Buena Vista		GA		US 31	803		Columbus		GA		US	31901			
Part II Emp									Plan Star	rt Month (ei	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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17 ZIP Code													1005.0		

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Cat. No. 60705M

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

Pa		oyer pro	vided self-insur	ed coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, m	covered ir iddle initia	ndividual(s) II, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	) Months June	of covera  July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Kari Kinser 1251 Front Avenue, Apt 101 Columbus, GA 31901

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

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

**CORRECTED** 

VOID

OMB No. 1545-2251

Internal Revenue Se	rvice		Go to www	v.irs.gov/For	m1095C for ins	structions a	nd the latest ir	itormation.						
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security number	(SSN)	7 Name of emp	oloyer			<b>8</b> En	nployer identific	cation number (EIN)	
Kari		Kinse	•		XXX-XX-48	325	W.C. Bradl	ey Co.		581605660				
3 Street address (i	ncluding apartr	ment no.)		'			9 Street addres	ss (including roo	<b>10</b> Co	10 Contact telephone number				
1251 Front Av	enue Apt	101					PO BOX 14	40		7065713405				
4 City or town		5 State or prov	ince	6 Count	6 Country and ZIP or foreign postal code				12 State or pr	ovince	<b>13</b> Co	untry and ZIP o	r foreign postal code	
Columbus		GA		US 31	US 31901				GA		US	31901		
Part II Emp	er of Cove	rage	s Age on	January 1	Plan Star	nter 2-digit r	er 2-digit number): 01							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
<b>14</b> Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
<b>17</b> ZIP Code														

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

Pa		oyer pro	vided self-insur	ed coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name, n	covered in niddle initia	idividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	) Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Kari		Kinser	XXX-XX-4825			$\times$	$\times$	$\times$	$\times$	X	$\times$	X	$\times$	$\times$	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

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

Shivani Kolluru 655 Greencrest Ln Milton, GA 30004

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CORRECTED

VOID

OMB No. 1545-2251

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

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

RRECTED 2023

Internal Revenue Se	ervice		Go to www	/.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	ntormation.							
Part I Emp	ployee						A	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, r	middle initial, la	ıst name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identific	ation number (EIN)		
Shivani		Kollur	·u		XXX-XX-9	509	W.C. Bradle	ey Co.		581605660					
3 Street address (	including apartm	nent no.)					9 Street addres	ss (including roc	<b>10</b> Ce	10 Contact telephone number					
655 Greencre	655 Greencrest Ln											7065713405			
4 City or town	5	5 State or prov	rince	6 Count	6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code		
Milton							Columbus		GA		US	31901			
Part II Emp	ployee Offe	er of Cove	rage	•	Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 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													1005 0		

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Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Katherine Krieg 620 Front Avenue Columbus, GA 31901

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	itormation.						
Part I Emp	ployee						Aı	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	yee (first name, m	iddle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)	
Katherine		Krieg			XXX-XX-34	456	W.C. Bradley Co.  9 Street address (including room or suite no.)  10					581605660		
3 Street address (i	including apartme	ent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> Ce	ontact telephone	number	
620 Front Ave	enue						PO BOX 14	40				706571	3405	
4 City or town	5	State or prov	rince	6 Count	ry and ZIP or forei	gn postal code				<b>13</b> Co	ountry and ZIP or	foreign postal code		
Columbus		3A		US 31	1901		Columbus GA			US	31901			
Part II Emp	ployee Offe	r of Cove	rage		Employee <sup>3</sup>	's Age on c	January 1		Plan Sta	rt Month (e	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			A.M. Walland										1005 C assess	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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#### Instructions for Recipient (continued)

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

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

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

Adam Lee 1251 Front Avenue, Unit 107 Columbus, GA 31901

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Depar						

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CORRECTED

OMB No. 1545-2251

VOID

2023

Internal Revenue Se	rvice		Go to ww	w.irs.gov/For	s.gov/Form1095C for instructions and the latest information.										
Part I Emp	oloyee						Α	pplicable l	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of em	oloyer			8 En	nployer identific	cation number (EIN)		
Adam		Lee			XXX-XX-18	337	W.C. Bradl	ey Co.				58160	581605660		
3 Street address (i	ncluding apartn	ment no.)		•			9 Street addre	ss (including roo	om or suite no.)		<b>10</b> Cd	ontact telephon	e number		
1251 Front Av	enue Unit	107					PO BOX 1	40				70657	13405		
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Co	untry and ZIP o	r foreign postal code		
Columbus		GA		US 31	1901		Columbus		GA		US	US 31901			
Part II Employee Offer of Coverage Employee's A						s Age on	January 1		Plan Star	rt Month (e	nter 2-digit ı	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
<b>14</b> Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
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Cat. No. 60705M

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#### Instructions for Recipient (continued)

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Rhonda Leeds 1101 N Yellowood Ave Broken Arrow, OK 74012

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

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

CORRECTED

VOID

OMB No. 1545-2251

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

PRRECTED | 2023

Internal Revenue Ser	vice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions a	nd the latest in	nformation.					<u></u>	
Part I Emp	loyee						Α	pplicable L	arge Emplo	oyer Memb	er (Em	ployer	)	
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer				8 Employ	er identifica	tion number (EIN)
Rhonda		Leeds			XXX-XX-32	284	W.C. Bradl	W.C. Bradley Co.					581605	660
3 Street address (in	ncluding apartm	ent no.)		•			9 Street address (including room or suite no.)				10 Contact telephone number			
1101 N Yellow	ood Ave						PO BOX 1	40					7065713	3405
4 City or town	5	State or provin	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province 1			3 Country	and ZIP or f	oreign postal code		
<b>Broken Arrow</b>		OK		US 74	012		Columbus		GA			US 319	01	
Part II Emp	loyee Offe	r of Cover	age		Employee <sup>3</sup>	's Age on					igit num	ber):	01	
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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Name of First name, m	covered i iddle initi	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	) Months June	of covera  July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

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

Pierre Lemieux 14755 NW 11th Place Newberry, FL 32669

OMB No. 1545-2251

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

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Internal Revenue Service Go to www.irs.gov/Form1095C for Instruction								ia the latest in	tormation.				"	<b></b>	
Part I Emp	oloyee							Aı	oplicable L	arge Emplo	yer Memb	er (Empl	oyer)		
1 Name of employ	ee (first name,	middle initia	I, last name)		2 Social	security number	er (SSN)	7 Name of emp	loyer			8 E	mployer identifi	cation number (EIN)	
Pierre		Ler	nieux			XXX-XX-2	739	W.C. Bradle	ey Co.				58160	05660	
3 Street address (i	ncluding apartr	ment no.)						9 Street address	s (including roc	<b>10</b> C	10 Contact telephone number				
14755 NW 11	th Place							PO BOX 14	10		7065713405				
4 City or town		5 State or p	province		6 Country and ZIP or foreign postal code			11 City or town		12 State or pr	ovince	<b>13</b> C	13 Country and ZIP or foreign postal code		
Newberry FL					US 32669			Columbus		GA		US	31901		
Part II Employee Offer of Coverage Em							's Age on J	January 1	Plan Star	t Month (er	ter 2-digit	digit number): 01			
	All 12 Months	Jan	Fel	b	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	10	<b>3</b>	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see nstructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
<b>17</b> ZIP Code															
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Kimberly Littmann N86 W28411 Scott Ln Hartland, WI 53029

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

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OMB No. 1545-2251

Internal Revenue Se			Go to www	irs.gov/Fo	rm1095C for ins	structions a	nd the latest i	nformation.		Z0 <b>Z3</b>				
Part I Emp	ployee						Α	Applicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Soci	al security number	r (SSN)	7 Name of em	ployer			<b>8</b> Er	nployer identifica	ation number (EIN)	
Kimberly		Littma	nn		XXX-XX-94	194	W.C. Brad	ley Co.				581605	5660	
3 Street address (i	including apartr	ment no.)		<u>'</u>			9 Street addre	ess (including roo	om or suite no.)		<b>10</b> Co	ontact telephone	number	
N86 W28411	Scott Ln						PO BOX 1	40				7065713405		
4 City or town		5 State or provi	nce	6 Count	6 Country and ZIP or foreign postal code			1	12 State or pr	ovince	<b>13</b> Co	ountry and ZIP or	foreign postal code	
Hartland WI					US 53029				GA		US	US 31901		
Part II Emp	ployee Off	er of Cover	rage	•	Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														

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

Cat. No. 60705M

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	(a) Name First name	of covered	individual(s) tial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	) Months June	of covera	Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Henry Lopes Horvath 6833 Omaha Dr Midland, GA 31820

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Intern	al Rev	enue Sei	vice

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

VOID OMB No. 1545-2251

Internal Revenue Se	ervice			Go to ww	w.irs.gov/F	orm1095C to	or instructions a	tions and the latest information. $\square \subseteq \square$								
Part I Emp	ployee								Applicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle init	tial, last	name)	<b>2</b> Soc	cial security nu	mber (SSN)	7 Name of er	mployer			8 Ei	mployer identific	ation number (EIN)		
Henry		Lo	pes l	Horvath		XXX-XX	(-3273	W.C. Brad	dley Co.				581605660			
3 Street address (i	including apartr	ment no.)						9 Street add	ress (including roo	<b>10</b> C	10 Contact telephone number					
6833 Omaha	Dr							PO BOX 140					7065713405			
4 City or town		5 State or	r provin	се	6 Cou	6 Country and ZIP or foreign postal code			n	12 State or p	rovince	<b>13</b> Co	13 Country and ZIP or foreign postal code			
Midland GA						US 31820			6	GA		US	US 31901			
Part II Emp	ployee Off	er of C	overa	age	•	Employ	ee's Age on	January 1		Plan Sta	<b>rt Month</b> (er	nter 2-digit	digit number): 01			
All 12 Months Jan Feb					Mar	Apr	May	June	June July		Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1.	A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code																

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

Cat. No. 60705M

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

Pa		<b>ed Individuals</b> oyer provided self-ir	nsured		e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
		covered individual(s) iddle initial, last name		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Henry	Lopes Ho	orvatl	XXX-XX-3273			$\times$	$\times$	$\times$	×	X	$\times$	X	X	$\times$	$\times$	$\times$	$\times$
19	Ligia	Campanh		XXX-XX-6245			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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Rhonda Machalk 8084 Wellington Trace Midland, GA 31820

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Interna	al Rev	enue	Servi	٠ -

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CORRECTED

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OMB No. 1545-2251

2023

Internal Revenue Se	evenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.														
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	/er)			
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Socia	I security number	(SSN)	7 Name of emp	oloyer	8 Em	B Employer identification number (EIN)					
Rhonda		Macha	ılk		XXX-XX-76	47	W.C. Bradl	ey Co.		581605660					
3 Street address (i	ncluding apartr	ment no.)					9 Street addre	ess (including room or suite no.)				10 Contact telephone number			
8084 Wellington	on Trace						PO BOX 1	40				706571	3405		
4 City or town 5 State or province 6 Country and ZIP or foreign postal co							11 City or town		12 State or pro	ovince	<b>13</b> Co	intry and ZIP or	foreign postal code		
Midland GA US 31820							Columbus		GA		US :	31901			
Part II Emp	oloyee Off	er of Cover	age	·	Employee's	s Age on c	January 1		Plan Star	t <b>Month</b> (ei	nter 2-digit r	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
<b>14</b> Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
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Cat. No. 60705M

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Pa	art III Cover	red Indiv loyer prov	<b>riduals</b> rided self-insur	ed coverage, check th			on for e	each inc	lividual	enrolle					employe	e. 🗵		-
	(a) Name of First name, n	f covered ind	dividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Λ	(e) May	) Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Jay Maley 344 Northlake Drive Cataula, GA 31804

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CORRECTED

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identifica	ation number (EIN)	
Jay		Maley	/		XXX-XX-49	919	W.C. Bradle	ey Co.				581605	6660	
3 Street address (i	ncluding apartr	ment no.)		<u>'</u>			9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number	
344 Northlake	Drive						PO BOX 14	40				706571	3405	
4 City or town		5 State or prov	/ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	<b>13</b> Co	ountry and ZIP or	foreign postal code	
Cataula		GA		US 31	804		Columbus GA				US	US 31901		
Part II Emp	oloyee Off	er of Cove	rage	•	Employee'	s Age on c						number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									No. 60705M				1095-C (2022)	

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Cat. No. 60705M

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#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X  $\times$  $\times$ |X|18 XXX-XX-4919 Jay Maley  $\times$  $\times$ X 19 **ANNA** MALEY XXX-XX-7512  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X| $|\times|$ LAURA **MALEY** XXX-XX-3646 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 **HOPE** MALEY XXX-XX-5580 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

Elizabeth Martin 1261 Virginia Avenue NE Atlanta, GA 30306

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	ber (Emple	oyer)		
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
Elizabeth		Martir	1		XXX-XX-7	257	W.C. Bradl	ey Co.				581605660		
3 Street address (i	ncluding apartm	nent no.)		<u>'</u>			9 Street addre	ss (including roc	m or suite no.)		<b>10</b> C	10 Contact telephone number		
1261 Virginia	Avenue NE						PO BOX 1	40				706571	3405	
4 City or town	į	5 State or prov	ince	6 Count	ry and ZIP or forei	ign postal code	11 City or town		12 State or p	province	<b>13</b> C	ountry and ZIP or	foreign postal code	
Atlanta		GA		US 30	0306		Columbus GA				US	US 31901		
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on .						number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			Act Notice see						No. 60705M				- 1095-€ (2022	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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Pa	art III Covere If Emplo	ed Individua oyer provided	ls self-insured co	overage, check the	e box and enter th	e informatio	on for e	ach ind	ividual	enrolled					mploye	ee. 🗵		
	(a) Name of First name, m	covered individual iddle initial, last na		b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Sallie Martin 6549 Waterford Road Columbus, GA 31904

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

CORRECTED

VOID

OMB No. 1545-2251

RRECTED 20

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

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

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ir	ntormation.							
Part I Emp	oloyee						Applicable Large Employer Member (Em					yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer				<b>8</b> En	8 Employer identification number (EIN)			
Sallie		Martin	1		XXX-XX-68	356	W.C. Bradl	ey Co.				581605660			
3 Street address (i	ncluding apartr	ment no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
6549 Waterfor	rd Road						PO BOX 14	40				706571	3405		
4 City or town 5 State or province				6 Counti	ry and ZIP or forei	gn postal code	<b>11</b> City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Columbus GA				US 31	1904		Columbus		GA		US	31901			
Part II Emp	loyee Off	er of Cove	rage		Employee <sup>3</sup>	s Age on c	lanuary 1		Plan Star	rt Month (er	t 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code									No. 60705M				1095-C (2022)		

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Cat. No. 60705M

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	(a) Name of First name, m			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Sarah Mason 525 Lake Road Ponte Verda Beach, FL 32082

Form	I 09:	5-C
Departi	ment of the	Treasury
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# **Employer-Provided Health Insurance Offer and Coverage**

CORRECTED

VOID

OMB No. 1545-2251

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

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2023

internal Revenue Sel	rvice		GO LO WWW	.irs.gov/ror	<i>111109</i> 5C 101 111	istructions ar	iu tile latest li	mormation.				1 -		
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	ber (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	2 Social security number (SSN)			7 Name of employer				8 Employer identification number (EIN)		
Sarah		Masor	n		XXX-XX-0	395	W.C. Bradl	ley Co.				581605660		
3 Street address (i	ncluding apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
525 Lake Roa	ıd						PO BOX 1	40				7065713405		
4 City or town 5 State or province			6 Countr	ry and ZIP or forei	ign postal code	11 City or town		12 State or p	province	<b>13</b> Co	ountry and ZIP or	foreign postal code		
Ponte Verda E	Ponte Verda Beach FL						Columbus		GA		US	US 31901		
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005.0	

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (e) Months of coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $\times$  $\times$ |X| $|\times|$ 18 Sarah Mason XXX-XX-0395  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ |X|LUCILLE XXX-XX-3327 19 MASON 20 21 22 23 24 25 26 27 28 29 30

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Christopher Maunz 1223 Weatherford St Auburn, AL 36830

	1 NO	K_r
Form	109	J-U
Depar	tment of the	e Treasury

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

CORRECTED

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest in	nformation.						
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer				8 Ei	8 Employer identification number (EIN)		
Christopher		Maun	Z		XXX-XX-42	239	W.C. Bradley Co.					581605660		
3 Street address (i	including apartm	nent no.)		•			9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
1223 Weather	1223 Weatherford St							40				706571	3405	
4 City or town 5 State or province			6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code		
Auburn AL					830		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	er of Cove	rage		Employee <sup>3</sup>	s Age on J			Plan Star	t Month (er	nter 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									N- 00705M				1005 C (2000)	

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Cat. No. 60705M

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#### Instructions for Recipient (continued)

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Michelle Maxwell 7605 E 82nd St N Owasso, OK 74055

OMB No. 1545-2251

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

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

**CORRECTED** 

VOID

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Michelle Maxwell XXX-XX-4826 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 7605 E 82nd St N **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Owasso OK US 74055 Columbus GA US 31901 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A required code) 1A 1A 1A 1A 1A 1A 1A 1A 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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

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

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

Pa	I <b>rt III Cover</b> If Emplo	ed Indi oyer pro	<b>viduals</b> ovided self-insur	red coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of First name, m	covered i	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Michelle		Maxwell	XXX-XX-4826	,		X	X	X	X	×	X	×	X	X	X	X	$\boxtimes$
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#### Instructions for Recipient (continued)

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

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

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

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

Jeffrey Mayhand 30 Lee Road 2205 Smiths Station, AL 36877

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	nformation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, m	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer 8				<b>8</b> Er	8 Employer identification number (EIN)		
Jeffrey		Mayh	and		XXX-XX-5	110	W.C. Bradle	ey Co.				581605	6660	
3 Street address (i	including apartme	ent no.)		•			9 Street addres	ss (including roo	m or suite no.)		<b>10</b> C	ontact telephone	number	
30 Lee Road	2205						PO BOX 14	40				706571	3405	
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code	
Smiths Station	n A	۸L		US 36	877		Columbus		GA		US	31901		
Part II Emp	oloyee Offer	r of Cove	rage		Employee <sup>3</sup>	s Age on J	lanuary 1		Plan Star	rt Month (ei	nter 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													1005 C (2000)	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Mayhand 18 **Jeffrey** XXX-XX-5110  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $|\times|$ X  $|\times|$  $\times$ TRISTAN 19 Н MAYHAND XXX-XX-0752  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|S MAYHAND XXX-XX-9797 20 **JOEY** 21 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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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

Velvet McCullough 3254 Junaluska Dr Columbus, GA 31907

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security number	r (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Velvet		McCı	ıllough		XXX-XX-60	)97	W.C. Bradley Co.					581605660			
3 Street address (including apartment no.)					9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	ntact telephone	number				
3254 Junalusk	ka Dr						PO BOX 1	40				706571	3405		
4 City or town		5 State or prov	vince	6 Count	try and ZIP or foreig	gn postal code	11 City or town		12 State or pro	ovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Columbus		GA		US 3	1907		Columbus		GA		US :	31901			
Part II Emp	loyee Off	er of Cove	rage	Employee's Age on January 1			on January 1 Plan Star			Plan Start Month (enter 2-d			digit number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
<b>14</b> Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|McCullough 18 Velvet XXX-XX-6097  $\times$  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ 19 NORMAN MCCULLOUG XXX-XX-8164  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X| $|\times|$ NORMAN MCCULLOUG XXX-XX-2652 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

Alden T Mercer 915 Tamarisk Place Canton, GA 30114

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

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www	v.irs.gov/Fo	<i>m10</i> 95C for in	nstructions a	nd the latest i	nformation.					
Part I Emp	ployee						A	Applicable I	arge Emp	loyer Memb	er (Empl	oyer)	
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)
Alden		T Merce	er		XXX-XX-8	422	W.C. Brad	ley Co.				58160	5660
3 Street address (i	including apart	ment no.)		<u>'</u>			9 Street addre	ess (including ro	om or suite no.)		10 (	Contact telephone	number
915 Tamarisk	Place						PO BOX 1	40				706571	3405
4 City or town		5 State or prov	vince	6 Count	try and ZIP or fore	eign postal code	11 City or town	1	12 State or	province	<b>13</b> C	Country and ZIP or	foreign postal code
Canton		GA		US 30	0114		Columbus		GA		US	31901	
Part II Emp	ployee Off	er of Cove	rage	•	Employee	's Age on	January 1		Plan Sta	art Month (e	nter 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			Addition										1005 0

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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	(a) Name of of First name, mi			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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	Adelynn	М	Mercer	XXX-XX-1204							$\times$	$\times$	$\times$	$\times$	$\times$	$\boxtimes$	$\boxtimes$	$\times$
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#### Instructions for Recipient (continued)

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Jennifer D Miller 299 Lee Road 2046 Smiths Station, AL 36877

Form	095-	·C
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## Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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

Part I Emp	oloyee						А	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	, middle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer	8 En	8 Employer identification number (EIN)				
Jennifer		D Miller			XXX-XX-8	745	W.C. Bradley Co.					581605660		
3 Street address (i	ncluding apart	tment no.)		<u>'</u>			9 Street address (including room or suite no.)					ontact telephone	number	
299 Lee Road	1 2046					PO BOX 1	40				706571	3405		
4 City or town		5 State or provi	nce	6 Counti	ry and ZIP or forei	gn postal code	11 City or town 12 State or pro			ovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Smiths Station	n	AL		US 36	877		Columbus GA			US 31901				
Part II Emp	oloyee Off	er of Cover	age	•	Employee <sup>3</sup>	s Age on	January 1		Plan Star	t Month (e	nter 2-digit ı	number):	01	
	All 12 Month	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 0	

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Cat. No. 60705M

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

Pa	I <b>rt III Cove</b> If Emp	red Indi	viduals vided self-ins	ured coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name ( First name,	of covered in	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Jennifer	D	Miller	XXX-XX-8745	,		X	X	X	X	×	X	×	X	X	X	X	$\boxtimes$
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#### Instructions for Recipient (continued)

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

Lovick P Miller 7200 Britton Columbus, GA 31904

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

VOID

OMB No. 1545-2251

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

3 Street address (including apartment no.) 7200 Britton 4 City or town Columbus Fart II Employee Offer of Coverage  All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code) Fequired Cool Contribution (see instructions) S S S S S S S S S S S S S S S S S S S	internal Revenue Sei	rvice			GO LO W	vv vv .11 3.	gov/i oii	11110930 101 1113	sti uctions ai	iu tile latest i	mormation.				- 1				
Lovick P   Miller	Part I Emp	oloyee								Applicable Large Employer Member (Employer)									
3 Street address (including apartment no.) 7200 Britton 4 City or town Columbus Fart II Employee Offer of Coverage    All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov     14 Offer of Coverage (enter required code)   1G   1G   1G   1G   1G     16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)   16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)   18 State or province   10 Contact telephone number   706571340!   10 Contact telephone number   706571340!   11 City or town   12 State or province   13 Country and ZIP or foreign   13 Country and ZIP or foreign   13 Country and ZIP or foreign   14 City or town   Columbus   Columbus	1 Name of employ	ee (first name,	middle	initial, las	t name)		2 Socia	al security number	r (SSN)	7 Name of em	ployer			8	Empl	oyer identificat	tion number (EIN)		
7200 Britton  4 City or town GA US 31904  Columbus  Fart II Employee Offer of Coverage  Employee's Age on January 1  14 Offer of Coverage (enter required code)  To Employee (enter required Code)  To Employee Required Code)  To Employee Required Required Required Contribution (see instructions)  To Exployee Required Relief (enter code, if applicable)	Lovick		Р	Miller				XXX-XX-5879			W.C. Bradley Co.						581605660		
4 City or town GA US 31904 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):  4 Offer of Coverage IG US 31901 Plan Start Month (enter 2-digit number):  4 Offer of Coverage (enter required code) IG	3 Street address (i	including apartr	ment n	0.)						9 Street addre	ess (including roo	m or suite no.)		10	<b>0</b> Conta	act telephone i	number		
Columbus GA US 31904 Columbus GA US 31901    Part II   Employee Offer of Coverage   Employee's Age on January 1   Plan Start Month (enter 2-digit number):   All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov     14 Offer of Coverage (enter required code)   1G   1G   1G   1G   1G   1G   1G   1	7200 Britton									PO BOX 140					7065713405				
Part II Employee Offer of Coverage    All 12 Months   Jan   Feb   Mar   Apr   May   June   July   Aug   Sept   Oct   Nov	4 City or town		5 Stat	te or provir	nce		6 Countr	6 Country and ZIP or foreign postal code			ı	12 State or pro	ovince	13	13 Country and ZIP or foreign postal code				
All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  15 Employee Required Contribution (see instructions)  \$\$\$ \$						US 31904			Columbus GA				L	JS 31	901				
14 Offer of Coverage (enter required code)         1G         1G<							Employee's Age on J				Plan Start Month (enter 2-digit number): 0					01			
Coverage (enter required code)		All 12 Months	5	Jan	Feb		Mar	Apr	May	June	July	Aug	Sept	Oc.	t	Nov	Dec		
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Safe Harbor and Other Relief (enter code, if applicable)	Required Contribution (see	\$	\$		\$	\$		\$	\$	\$	\$	\$	\$	\$		\$	\$		
17 ZIP Code	Safe Harbor and Other Relief (enter																		
	17 ZIP Code																		

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Alison Moffett 658 TOWNE LAKE PKWY OPELIKA, AL 36804

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

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	nployer identific	ation number (EIN)		
Alison		Moffe	tt		XXX-XX-19	961	W.C. Bradl	ley Co.				581605660			
3 Street address (i	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
658 TOWNE I	LAKE PKW	Υ					PO BOX 1	40				706571	3405		
4 City or town	5	State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town 12 State or province				<b>13</b> Co	untry and ZIP or	foreign postal code		
OPELIKA	A	AL		US 36	804		Columbus GA				US	US 31901			
Part II Emp	oloyee Offe	r of Cove	rage		Employee <sup>3</sup>	's Age on c					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			And Mading of										1005 € (2000)		

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

Cat. No. 60705M

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#### Instructions for Recipient (continued)

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William Moshell II 546 GA Highway 219 Fortson, GA 31808

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

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

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest in	nformation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	/ee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identific	ation number (EIN)	
William		Mosh	ell		XXX-XX-6	765	W.C. Bradle	ey Co.				58160	5660	
3 Street address (i	including apartn	nent no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number		
546 GA Highway 219							PO BOX 14	40				706571	3405	
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	l -				<b>13</b> Co	ountry and ZIP or	foreign postal code	
Fortson		GA		US 31	1808		Columbus GA U				US	US 31901		
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee <sup>3</sup>	s Age on J					nter 2-digit	number):		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									No. COZOSM				1005 C (2000)	

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Cat. No. 60705M

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 William Moshell XXX-XX-6765  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 **REBECCA** M MOSHELL XXX-XX-6890  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|**MOSHELL** 20 LILLY XXX-XX-4668 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 **LUCY MOSHELL** XXX-XX-8384 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

Steven Owen 254 Willow Beach Rd Ellerslie, GA 31807

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

DRRECTED 2023

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	ntormation.							
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identific	ation number (EIN)		
Steven		Owen			XXX-XX-6	593	W.C. Bradle	ey Co.				58160	5660		
3 Street address (i	including apartn	nent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number			
254 Willow Be	each Rd						PO BOX 14	40				706571	3405		
4 City or town		5 State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code				rovince	<b>13</b> Co	ountry and ZIP or	foreign postal code		
Ellerslie		GA		US 31	1807		Columbus GA				US	US 31901			
Part II Emp	oloyee Offe	er of Cove	rage		Employee'	s Age on J	January 1 Plan Start Month (enter 2-dig				nter 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			A at Nation										1005 0 (2000)		

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

Christopher Pass 8272 Dream Boat Dr, Apt 737 Columbus, GA 31909

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	oyer)		
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of employer					8 Employer identification number (EIN)		
Christopher Pass					XXX-XX-9	065	W.C. Brad	ley Co.				58160	5660	
3 Street address (in	3 Street address (including apartment no.)							ess (including roo	m or suite no.)		<b>10</b> C	ontact telephone	number	
8272 Dream E	Boat Dr Apt	737					PO BOX 1	40				706571	3405	
4 City or town						ign postal code	11 City or town		12 State or p	province	<b>13</b> C	ountry and ZIP or	foreign postal code	
Columbus GA			US 3 <sup>2</sup>	1909		Columbus		GA		US	31901			
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on J	January 1		Plan Sta	rt Month (e	nter 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													1005 0	

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Cat. No. 60705M

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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Christopher **Pass** XXX-XX-9065  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|**Pass** XXX-XX-7281 19 Ryan  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Asha ElDorrado XXX-XX-8336 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 **Pass** XXX-XX-0705 Ivan 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

Ambrish Patel 9796 N Ivy Park Dr Fortson, GA 31808

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

VOID

OMB No. 1545-2251

Internal Revenue Se	rnal Revenue Service Go to www.irs.gov/Form1095C for instructions a							nformation.						
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of employer					8 Employer identification number (EIN)		
Ambrish		Patel			XXX-XX-30	015	W.C. Bradle	ey Co.				581605	5660	
3 Street address (i	3 Street address (including apartment no.)						9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number	
9796 N Ivy Park Dr						PO BOX 14	40				706571	3405		
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Fortson	(	GA		US 31	808		Columbus		GA		US	JS 31901		
Part II Emp	oloyee Offe	r of Cove	rage	'	Employee <sup>3</sup>	s Age on J	January 1		Plan Start Month (enter 2-digit num			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			Act Notice on						No. COZOSM				1005 C (2000)	

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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#### Instructions for Recipient (continued)

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Marian B Ross 2649 Greenville Road LaGrange, GA 30241

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice	Go to www.irs.gov/Form1095C for instructions and the latest information.												
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	yer)		
1 Name of employ	/ee (first name, r	middle initial, la	ıst name)	2 Socia	al security numbe	er (SSN)	7 Name of employer					8 Employer identification number (EIN)		
Marian		B Ross			XXX-XX-26	618	W.C. Bradl	ey Co.				58160	5660	
3 Street address (including apartment no.)							9 Street addre	ss (including roc	m or suite no.)		<b>10</b> Co	ntact telephone	number	
2649 Greenvi	lle Road						PO BOX 1	40				706571	3405	
4 City or town	ŧ	5 State or prov	vince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
LaGrange		GA		US 30	)241		Columbus		GA		US:	US 31901		
Part II Emp	oloyee Offe	er of Cove	rage		Employee <sup>2</sup>	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit r	-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													1005 0	

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

Cat. No. 60705M

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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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Cynthia L Sanford 12847 AL Hwy 51 Opelika, AL 36804

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Form	1033-	U
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## **Employer-Provided Health Insurance Offer and Coverage**

CORRECTED

VOID

OMB No. 1545-2251

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2023

Internal Revenue Sei	rvice		GO TO WWW	irs.gov/For	m 1095C for in	structions ar	ia the latest ir	ntormation.				`			
Part I Emp	oloyee						Α	pplicable L	arge Empl	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	er (SSN)	7 Name of emp	ployer			8 En	nployer identific	ation number (EIN)		
Cynthia		L Sanfo	rd		XXX-XX-18	344	W.C. Bradley Co.					581605660			
3 Street address (i	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	ss (including roc	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
12847 AL Hw	y 51						PO BOX 140					7065713405			
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Opelika AL US 36804							Columbus		GA		US	31901			
Part II Employee Offer of Coverage Employee's A						's Age on	January 1		Plan Sta	rt Month (e	nter 2-digit r	2-digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III Covere			ed coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of of First name, mi			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

William M Scarbrough 8500 Lake Bright Dr Columbus, GA 31904

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		GO to www	v.irs.gov/For	m 1095C for in	structions ar	ia the latest in	itormation.						
Part I Emp	ployee						Aı	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	/ee (first name, i	middle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identifica	ation number (EIN)	
William		M Scarb	rough		XXX-XX-94	108	W.C. Bradley Co.					581605660		
3 Street address (i	including apartn	nent no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Cd	10 Contact telephone number		
8500 Lake Bri	ight Dr						PO BOX 14	40				7065713405		
4 City or town		5 State or prov	rince	6 Counti	6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Columbus GA US 31904					904		Columbus		GA		US	31901		
Part II Employee Offer of Coverage Employee's Age						s Age on c	January 1		Plan Star	rt Month (ei	nter 2-digit ı	number):	01	
All 12 Months Jan Feb Mar Apr					May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005.0	

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

Cat. No. 60705M

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$  $\times$  $\times$  $\times$ |X|Scarbrough William XXX-XX-9408 18 M  $\times$ X X |X| $|\times|$  $\times$ X X  $|\times|$ |X||X|Winn Scarbrough XXX-XX-4364 19  $\times$  $\times$  $\times$  $\times$ |X||X||X|X |X||X| $\times$  $|\times|$ William Ν Scarbrough XXX-XX-3921  $\times$ |X||X||X| $\times$ |X||X|X  $\times$ |X||X||X|Scarbrough XXX-XX-5199 21 Jana  $\times$  $\times$  $\times$ |X|X |X|X |X|X |X|22 Scarbrough XXX-XX-8337 Harry  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ X  $\times$  $\times$  $\times$ Scarbrough XXX-XX-0353 23 Lela 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

Martin Schroeder 4695 Winged Foot Way Columbus, GA 31909

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

CORRECTED

VOID

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

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Martin Schroeder XXX-XX-8213 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 4695 Winged Foot Way **PO BOX 140** 7065713405 5 State or province 4 City or town 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Columbus US 31909 Columbus GA 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 Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A required code) 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

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#### Instructions for Recipient (continued)

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Lindsey Smallwood 2577 Lee Road 250 Salem, AL 36874

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

**CORRECTED** 

VOID

OMB No. 1545-2251

Internal Revenue Service

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

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Lindsev Smallwood XXX-XX-8164 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 2577 Lee Road 250 **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code ΑL Salem US 36874 Columbus GA US 31901 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1A required code) 1A 1A 1A 1A 1A 1A 1A 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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#### Part I. Applicable Large Employer Member (Employer)

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

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- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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	(a) Name of of First name, mi		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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

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

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

Jessica Dawn Smith 3320 Judge Brown Rd Valley, AL 36854

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

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee					Applicable Large Employer Member (Employer)									
1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)								7 Name of employer 8 Employer identification nu							
Jessica		D Smith			XXX-XX-62	220	W.C. Bradl	ey Co.				581605660			
3 Street address (in	ncluding apartr	ment no.)					9 Street addre	ss (including roor	n or suite no.)		<b>10</b> Cor	ntact telephone r	number		
3320 Judge B	rown Rd						PO BOX 1	40				7065713	405		
4 City or town		5 State or prov	ince	6 Country	/ and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	<b>13</b> Cou	ntry and ZIP or fo	reign postal code		
Valley		AL		US 368	854		Columbus		GA		US 3	1901			
Part II Emp	loyee Off	er of Cove	rage	·	Employee'	s Age on J	January 1		Plan Star	t Month (en	ter 2-digit n	-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

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered TIN is not available) First name, middle initial, last name all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|D Smith XXX-XX-6220 18 Jessica  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$ X 19 David Н Smith XXX-XX-2281  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|S Mackenzie Yeast XXX-XX-4260 X |X||X||X| $\times$ |X||X|X |X||X||X|Fey<u>en</u> Cameron XXX-XX-2127 Α  $\times$  $\times$  $\times$  $\times$ X |X||X| $\times$ 22 Kash Ε Smith XXX-XX-0695 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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Kenneth Solomons IV 8242 Preservation Trl Midland, GA 31820

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)			
Name of employee (first name, middle initial, last name)     Social security number (SSN)								ployer			8 E	8 Employer identification number (EIN)			
Kenneth		Solon	nons		XXX-XX-3	575	W.C. Brad	ley Co.				58160	5660		
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ess (including roc	m or suite no.)		<b>10</b> C	ontact telephone	number		
8242 Preserva	ation Trl						PO BOX 1	40				706571	3405		
4 City or town	5	State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	ı	12 State or	province	<b>13</b> C	ountry and ZIP or	foreign postal code		
Midland	(	GA		US 3	US 31820				GA		US	US 31901			
Part II Emp	oloyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	ert Month (e	enter 2-digit	2-digit number):			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A Act Notice on						N. 00705M				1005 C (2000		

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

Cat. No. 60705M

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	(a) Name of First name, m			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

Hunter Spicer 2100 Lancelot PI Columbus, GA 31904

111UK_1
Form <b>1095-G</b>
Department of the Treasury
Internal Revenue Service

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	oyer Meml	ber (Empl	oyer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer			8	Employer identific	ation number (EIN)		
Hunter		Spice			XXX-XX-97	743	W.C. Bradley Co.					581605660			
3 Street address (i	including apartr	nent no.)		<u>'</u>			9 Street addre	ess (including roc	om or suite no.)		10 (	10 Contact telephone number			
2100 Lancelo	t PI						PO BOX 1	40				706571	3405		
4 City or town		5 State or prov	rince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	13 (	Country and ZIP or	foreign postal code		
Columbus GA US 31904									GA		US	S 31901			
Part II Emp	oloyee Offe	er of Cove	rage	!	Employee'	s Age on	January 1		Plan Sta	rt Month (e	nter 2-digi	t 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													1005.0		

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

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

Pa	I <b>rt III</b> Covere		ed coverage, check th			on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Hunter	Spicer	XXX-XX-9743			X	×	X	X	×	×	×	X	X	$\boxtimes$	×	$\times$
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Jo Thomas 132 Crosscreek Drive Smiths Station, AL 36877

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Depar						

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VOID

OMB No. 1545-2251

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

Internal Revenue Sei	vice		GO LO WWW	i.irs.gov/Foi	11110950 101 11	istructions ar	iu trie latest i	mormation.				1 -	
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)	
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)
Jo		Thom	as		XXX-XX-5	945	W.C. Brad	ley Co.		58160	5660		
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ess (including roc	m or suite no.)		<b>10</b> C	ontact telephone	number
132 Crosscree	ek Drive						PO BOX 1	40				706571	3405
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	ı	12 State or	province	<b>13</b> C	ountry and ZIP or	foreign postal code
Smiths Station	1 /	AL		US 36	6877		Columbus		GA		US	31901	
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			A Act Notice as						N. 00705M				1005 C (2000

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Cat. No. 60705M

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	(a) Name of c First name, mid		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Jo	Thomas	XXX-XX-5945			X	X	X	X	X	×	X	X	X	$\times$	$\times$	$\times$
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#### Part III. Covered Individuals, Lines 18–30

Latoya N Thomas 3865 Hawaii Way, Apt 2 Columbus, GA 31906

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Ser	vice		GO LO WWW	.irs.gov/rori	11110950 101 111	structions ar	iu trie latest ii	normation.				`			
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Empl	oyer)			
1 Name of employe	ee (first name, n	niddle initial, las	st name)	2 Socia	I security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)		
Latoya		N Thoma	as		XXX-XX-6	930	W.C. Bradl	ey Co.		58160	5660				
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 0	10 Contact telephone number			
3865 Hawaii V	Vay Apt 2						PO BOX 1	40				7065713405			
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	<b>13</b> C	ountry and ZIP or	foreign postal code		
Columbus	(	GA		US 31	906		Columbus		GA		US	31901			
Part II Emp	loyee Offe	r of Cover	age		Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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17 ZIP Code													1005.0		

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Cat. No. 60705M

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#### Part I. Employee

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

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

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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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Pa	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.  (a) Name of covered individual(s)  (b) SSN or other TIN  (c) DOB (if SSN or other (d) Covered  (e) Months of coverage																	
			ndividual(s) ıl, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Latoya	N	Thomas	XXX-XX-6930								X	X	X	$\times$	X	X	$\times$
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#### Part III. Covered Individuals, Lines 18–30

Barbara Turner 896 Virginia Cir NE Atlanta, GA 30306

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						А	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)		
1 Name of employee (first name, middle initial, last name)  2 Social security number (SSN)					7 Name of em	ployer			8 En	8 Employer identification number (EIN)				
Barbara		Turne	er		XXX-XX-1	594	W.C. Bradl	ley Co.				581605660		
3 Street address (i	ncluding apartn	nent no.)		<u>'</u>			9 Street addre	ess (including roc	m or suite no.)		<b>10</b> Cd	ontact telephone	e number	
896 Virginia C	Cir NE						PO BOX 1	40				706571	13405	
4 City or town	:	5 State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Atlanta		GA		US 30	0306		Columbus		GA		US	US 31901		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	nter 2-digit ı	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 0 200	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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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Pa	rt III Covere		ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of o		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Bradley Turner 6950 Hilltop Ct Columbus, GA 31904

Form 1095-C
Form IUJJ-U
Department of the Treasury
Internal Revenue Service

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

VOID

OMB No. 1545-2251

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

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1 Name of employee (first name, middle initial, last name)  2 Social security number (SSN)									nployer identific	ation number (EIN)				
Bradley		Turne	er		XXX-XX-9	423	W.C. Bradl	ley Co.				581605660		
3 Street address (i	ncluding apartr	nent no.)		<u>'</u>			9 Street addre	ess (including roc	om or suite no.)		<b>10</b> Co	ntact telephone	e number	
6950 Hilltop C	Ct .						PO BOX 1	40				706571	3405	
4 City or town		5 State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Columbus		GA		US 3	1904		Columbus		GA		US	US 31901		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 0	

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Cat. No. 60705M

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- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 **Bradley** XXX-XX-9423 Turner  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Christian Α Wehrhahn XXX-XX-4581  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|Amandah Wehrhahn XXX-XX-9931 X |X||X||X| $\times$ |X||X|X |X||X||X||X|21 Cristian Α Wehrhahn XXX-XX-5216 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

Cathey Turner 109 Graystone Court Columbus, GA 31904

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

**CORRECTED** 

VOID

OMB No. 1545-2251

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

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Cathev Turner XXX-XX-7849 581605660 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 109 Graystone Court **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Columbus US 31904 Columbus GA US 31901 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1G required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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

Don Abbott Turner III 5185 Midland Trace Midland, GA 31820

OMB No. 1545-2251

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

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

VOID

internal Revenue Se	rvice			GO LO WW	w.ii S.	.gov/rom	11095	C IOI III	structions ar	ia trie	iatest iii	iormatio	11.				- 1			
Part I Emp	oloyee								Ap	plicab	le La	rge Emplo	yer Memb	er (E	Employ	er)				
1 Name of employ	ee (first name,	middle ir	nitial, last	t name)		2 Social	securit	y numbe	r (SSN)	7 Nar	ne of emp	loyer					8 Emp	loyer	identificatio	n number (EIN)
Don		А	Turner				XXX	-XX-35	520	W.C	. Bradle	ey Co.						5	816056	60
3 Street address (i	including apartr	ment no.)	)			•				9 Stre	et addres	s (includin	g room	or suite no.)			<b>10</b> Conf	tact te	elephone nu	ımber
5185 Midland	Trace									PO E	3OX 14	0						70	0657134	105
4 City or town 5 State or province 6 Country and ZIP or foreign postal cod							gn postal code	<b>11</b> City	or town			12 State or pro	ovince		13 Cour	itry an	d ZIP or for	eign postal code		
Midland		GA				US 318	320			Columbus				GA	US 31901					
Part II Emp	oloyee Off	er of C	Cover	age			Emp	loyee'	s Age on c	January 1 Plan Star					t <b>Month</b> (en	ter 2	?-digit nu	ımbe	er):	01
	All 12 Months	3 .	Jan	Feb		Mar		Apr	May		June	Jul	у	Aug	Sept		Oct		Nov	Dec
14 Offer of Coverage (enter required code)		1	1G	1G		1G		1G	1G		1G	10	ĵ	1G	1G		1G		1G	1G
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$		\$		\$	\$	\$		\$		\$
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
<b>17</b> ZIP Code																				

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

Cat. No. 60705M

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#### Instructions for Recipient (continued)

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

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

John Turner 6950 Hilltop Court Columbus, GA 31904

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Interna	al Rev	enue	Servi	٠ -

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

RECTED 20**23** 

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ii	nformation.					
Part I Emp	oloyee						Α	pplicable L	er (Emplo	yer)			
1 Name of employ	/ee (first name, n	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Ei	mployer identifica	ation number (EIN)
John		Turne	r		XXX-XX-3	736	W.C. Bradl	ley Co.				581605	5660
3 Street address (i	including apartm	ent no.)					9 Street addre	ss (including roc	m or suite no.)		<b>10</b> C	ontact telephone	number
6950 Hilltop C	Court						PO BOX 1	40				706571	3405
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code
Columbus		GA		US 31	1904		Columbus		GA		US	31901	
Part II Emp	oloyee Offe	r of Cove	rage	•	Employee	s Age on c	January 1		Plan Star	rt Month (ei	nter 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	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)						2A	2A	2A	2A	2A	2A	2A	2A
17 ZIP Code			Albaria										1005 0 2000

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

Cat. No. 60705M

## **Instructions for Recipient**

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

Pa	Irt III Covered If Employ	d Individuals ver provided se	lf-insured coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of co	overed individual(s) dle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	John	Turnei				X	X	×	X				Aug	С			
19	AMANDAH	TURN	ER XXX-XX-4262			$\times$	$\times$	$\times$	$\times$								
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#### Part III. Covered Individuals, Lines 18–30

Joseph Gardiner Turner 3542 19th Street Boulder, CO 80304

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Depar	tme	ent d	of th	ne T	rea	sury

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

CORRECTED

VOID

OMB No. 1545-2251

Department of the Treasury

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

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

RRECTED 2023

Internal Revenue Se	ervice		Go to ww	vw.irs.gov/Fo	<i>rm10</i> 95C for II	nstructions ar	nd the latest ir	nformation.					
Part I Emp	ployee						Α	pplicable L	er (Emplo	yer)			
1 Name of employ	/ee (first name, i	middle initial	, last name)	2 Soc	ial security numb	er (SSN)	7 Name of emp	ployer			<b>8</b> Er	nployer identific	ation number (EIN)
Joseph		G Turr	ner		XXX-XX-8	215	W.C. Bradl	ey Co.				58160	5660
3 Street address (i			9 Street addre	ss (including roo	om or suite no.)		<b>10</b> C	10 Contact telephone number					
3542 19th Str	eet						PO BOX 1	40				706571	3405
4 City or town		5 State or p	rovince	6 Coun	try and ZIP or fore	ign postal code	11 City or town		12 State or p	orovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code
Boulder		CO		US 8	0304		Columbus		GA		US	31901	
Part II Emp	ployee Offe	er of Cov	verage	•	Employee	's Age on <b>.</b>	January 1		Plan Sta	rt Month (e	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			- A SAN SE										1005 0 2222

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

Cat. No. 60705M

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Pa	i <b>rt III</b> C	<b>Covere</b> Employ	<b>d Indi</b> yer pro	<b>viduals</b> vided self-insı	ured coverage, check th	e box and enter th	ne information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	<b>(a)</b> N First n	lame of co	overed ir Idle initia	dividual(s) I, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Thompson Turner Jr 1050 W Conway Drive NW Atlanta, GA 30327

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

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	yer)		
1 Name of employ	vee (first name, n	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			<b>8</b> En	nployer identific	ation number (EIN)	
Thompson		Turne	r		XXX-XX-26	551	W.C. Bradl	ley Co.				581605660		
3 Street address (i	including apartm	ent no.)					9 Street addre	ss (including roc	om or suite no.)		<b>10</b> Co	ontact telephone	e number	
1050 W Conw	vay Drive N	W					PO BOX 1	40				706571	3405	
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign postal coordinates to the country and ZIP or foreign postal country and ZI				gn postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code		
Atlanta	(	GA		US 30	)327		Columbus		GA			US 31901		
Part II Emp	oloyee Offe	r of Cove	rage		Employee <sup>3</sup>	's Age on c	January 1		Plan Sta	rt Month (e	enter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			Addition										1005 0	

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Cat. No. 60705M

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

Pa	Irt III Covere	d Individuals yer provided self-in	sured coverage, check th	ne box and enter th	e informati	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of c	overed individual(s) ddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e May	June	of covera	ge	Sept	Oct	Nov	Dec
18	Thompson	Turner	XXX-XX-2651			X					June		Aug	С			
19																	
20																	
21																	
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#### Instructions for Recipient (continued)

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

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

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

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

William Clark Turner 243 Boat Club Way Hamilton, GA 31811

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

CORRECTED

VOID

OMB No. 1545-2251

2023

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

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

Internal Revenue Se	rvice		Go to www	/.irs.gov/For	m1095C for in	structions ar	nd the latest ir	ntormation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer			<b>8</b> Er	nployer identific	ation number (EIN)	
William		C Turne	er		XXX-XX-6	174	W.C. Bradl	ey Co.				581605660		
3 Street address (i	ncluding apartr	nent no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number	
243 Boat Club	o Way						PO BOX 14	40				706571	3405	
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Hamilton		GA		US 31	1811		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	er of Cove	rage		<b>Employee</b>	's Age on c	January 1		Plan Sta	rt Month (e	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									No. 60705M				1095-C (2022)	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|С 18 William XXX-XX-6174 Turner  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 LORI **TURNER** XXX-XX-0145  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|TURNER **JULIANNE** В XXX-XX-1463 X |X||X||X| $\times$ |X||X|X |X||X||X||X|DELANEY TURNER XXX-XX-1176 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Sue Waddell 20 S Roscoe Blvd Ponte Verda Beach, FL 32082

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

CORRECTED

VOID

OMB No. 1545-2251

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

20**23** 

internal Revenue Se	rvice		GO LO WWW	.ii s.gov/roi	11110950 101 111	Structions an	iu tile latest il	normation.							
Part I Emp	oloyee						Aı	pplicable L	arge Empl	oyer Memb	er (Emp	loyer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identifica	ation number (EIN)		
Sue		Wadd	ell		XXX-XX-3	700	W.C. Bradle	ey Co.				581605660			
3 Street address (i	ncluding apart	ment no.)					9 Street address	ss (including roo	m or suite no.)		10	Contact telephone	number		
20 S Roscoe	Blvd						PO BOX 14	40				706571	3405		
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	<b>11</b> City or town		12 State or p	rovince	13	Country and ZIP or	foreign postal code		
Ponte Verda E	3each	FL		US 32	2082		Columbus		GA		U	S 31901			
Part II Emp	oloyee Off	er of Cove	rage		Employee <sup>3</sup>	s Age on J	January 1		Plan Star	rt Month (ei	nter 2-dig	it number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 C (2000)		

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X  $\times$  $\times$ |X|18 Sue Waddell XXX-XX-3700  $\times$ X X |X| $|\times|$ |X|X  $|\times|$ |X||X|19 **ELIZA** WADDELL XXX-XX-3247  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X| $|\times|$ **BRADLEY** WADDELL XXX-XX-2421  $\times$ |X||X||X| $\times$ |X||X|X |X||X||X||X|**MATILDA** WADDELL XXX-XX-7443  $\times$  $\times$  $\times$  $\times$ X |X|X  $\times$ |X|**BRADLEY** WADDELL XXX-XX-4652 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Satish Waghmare 9240 Colham Drive Cumming, GA 30041

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Intern	al Roy	ם ווחם	Sarvio	20

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest ii	ntormation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)		
1 Name of employ	vee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)	
Satish		Wagh	mare		XXX-XX-4	365	W.C. Bradl	ey Co.				581605660		
3 Street address (i	including apartm	ent no.)		'			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number		
9240 Colham	Drive						PO BOX 1	40				706571	3405	
4 City or town	5	State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Cumming		GΑ		US 30	0041		Columbus		GA		US :	31901		
Part II Emp	oloyee Offe	r of Cove	rage		Employee	's Age on J	lanuary 1		Plan Sta	rt Month (e	nter 2-digit r	iumber):	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													1005 € (2000)	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|Waghmare 18 Satish XXX-XX-4365  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 **SAISHA** S WAGHMARE XXX-XX-5169  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X| $|\times|$ S **WAGHMARE ARPANA** XXX-XX-0183 X |X||X||X| $\times$ |X||X|X |X||X||X||X|**AKSHAT** S WAGHMARE XXX-XX-7574 22 23 24 25 26 27 28 29

#### Instructions for Recipient (continued)

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

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

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

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

Hannah Wainright 67 North 7th Street Brooklyn, NY 11249

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

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

CORRECTED

VOID

OMB No. 1545-2251

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

Service

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

RRECTED | 2023

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	ntormation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, m	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer 8					mployer identific	ation number (EIN)	
Hannah		Wainr	ight		XXX-XX-8	708	W.C. Bradley Co.					581605660		
3 Street address (i	including apartme	ent no.)					9 Street addres	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
67 North 7th S	Street						PO BOX 14	40				706571	3405	
4 City or town 5 State or province 6 Country and ZIP or foreign postal code						11 City or town		12 State or pr	rovince	<b>13</b> Cd	ountry and ZIP or	foreign postal code		
Brooklyn	l l	1Y		US 11	249		Columbus GA					31901		
Part II Emp	oloyee Offe	r of Cove	rage	•	Employee <sup>3</sup>	s Age on J	lanuary 1		Plan Star	rt Month (ei	nter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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17 ZIP Code													1005 C (2000)	

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Cat. No. 60705M

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

Pa	I <b>rt III Cover</b> If Emplo	ed Individuals oyer provided self	f-insured coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of First name, m	covered individual(s) iddle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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#### 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

Stueart Wainright 57 Wildlife Preserve Drive Saint Simons Island, GA 31522-4847

Form 1095-G	
Department of the Treasury	
Internal Revenue Service	

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

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ee (first name, m	niddle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
	Wainr	ight		XXX-XX-30	013	W.C. Bradl	ley Co.				5660		
ncluding apartm	ent no.)		'			9 Street addre	ss (including roo	m or suite no.)		10 0	10 Contact telephone number		
eserve Drive	Э					PO BOX 1	40				706571	3405	
5	State or provi	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	<b>13</b> C	ountry and ZIP or	foreign postal code	
Island	GA		US 31	522-4847		Columbus GA					31901		
oloyee Offe	r of Cove	rage	·	Employee'	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01	
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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

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

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

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Pa	Irt III Covere	ed Indivoyer prov	<b>/iduals</b> /ided self-insure	ed coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered in	dividual(s) , last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Stueart		Wainright	XXX-XX-3013			X	X	X	X	×	X	×	X	X	$\times$	X	$\boxtimes$
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#### Part III. Covered Individuals, Lines 18–30

Susan Wainwright 4243 Lakehaven Drive NE Atlanta, GA 30319

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

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Part I Emp	oloyee										Apı	olicable La	arge Emplo	yer Membe	r (E	mploy	er)			_
1 Name of employ	ee (first name,	middle	initial, las	st name)		2 Social	secur	rity number	r (SSN)	7 Name o	f emplo	yer				8 Employer identification number (EIN)				
Susan			Wainw	/right			XXX-XX-0617 W.C. Bradley Co.						581605660					60		
3 Street address (i	ncluding apartr	ment n	o.)							9 Street address (including room or suite no.)					10 Contact telephone number					
4243 Lakehav	en Drive N	ΙE								PO BO	X 140	)				7065713405				
4 City or town 5 State or province				6 Country	and Z	ZIP or foreig	gn postal code	<b>11</b> City or t	own		12 State or pro	ovince		13 Coun	try and	ZIP or fore	eign postal code			
Atlanta		GA				US 30	319			Columb	us		GA			US 3	1901			
Part II Emp	oloyee Off	er of	Cover	age			Emp	ployee'	s Age on J	lanuary	anuary 1 Plan Start Month (enter 2-digit number):					r):	01			
	All 12 Months	3	Jan	Feb		Mar		Apr	May	Jun	е	July	Aug	Sept		Oct		Nov	Dec	
<b>14</b> Offer of Coverage (enter required code)			1G	1G		1G		1G	1G	10	ì	1G	1G	1G		1G		1G	1G	_
<b>15</b> Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$		\$	\$	\$	\$		\$		\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
<b>17</b> ZIP Code																				

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

Cat. No. 60705M

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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|Wainwright 18 Susan XXX-XX-0617  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $|\times|$ X  $|\times|$  $\times$ 19 **KEITH** WOOD XXX-XX-5940  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|WOOD **EMILY** XXX-XX-6336 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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Anthony Wallace 3511 5th Avenue Phenix City, AL 36867

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

VOID

OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	nformation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, mi	ddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of employer					nployer identific	ation number (EIN)	
Anthony		Walla	ce		XXX-XX-02	279	W.C. Bradley Co.					581605660		
3 Street address (i	including apartme	nt no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
3511 5th Aver	nue						PO BOX 140					706571	3405	
4 City or town	4 City or town 5 State or province 6 Cou					gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Co	ountry and ZIP or	foreign postal code	
Phenix City AL US 36867							Columbus		GA		US	31901		
Part II Emp	oloyee Offer	of Cove	rage		Employee <sup>3</sup>	s Age on J	lanuary 1		Plan Star	rt Month (ei	nter 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	
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17 ZIP Code													1005 C (222	

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Cat. No. 60705M

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

Pa	If Employ	d Indiv	<b>viduals</b> vided self-insure	d coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	e. 🗵		-
	(a) Name of co			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	1	F-1-	N4	A		Months			01	0-4	Nan	D
	T if St Harrie, Trice		, last hame		The is not available)	dii 12 mondis	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Anthony		Wallace	XXX-XX-0279			$\times$	$\times$	$\boxtimes$	$\boxtimes$	$\times$	$\boxtimes$	$\times$	$\boxtimes$	$\boxtimes$	$\times$	$\boxtimes$	$\times$
19	MICHELLE		WALLACE	XXX-XX-2245			$\times$	$\times$	$\boxtimes$	$\times$	X	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

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

**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

Lulie Wallace 6447 Waterford Rd Columbus, GA 31904

OMB No. 1545-2251

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Form	IU	<i>)</i> 95	<b>-</b> U
Depar	tment	of the Ti	reasury
Interna	al Rev	enue Sei	vice

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

VOID

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

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	ntormation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, m	iddle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of employer					mployer identific	ation number (EIN)	
Lulie		Walla	ce		XXX-XX-0	780	W.C. Bradley Co.					581605660		
3 Street address (i	including apartme	ent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number		
6447 Waterfo	rd Rd						PO BOX 14	40				706571	3405	
4 City or town	4 City or town 5 State or province 6					gn postal code	<b>11</b> City or town		12 State or p	rovince	<b>13</b> Co	ountry and ZIP or	foreign postal code	
Columbus		SA		US 31	1904		Columbus		GA		US	31901		
Part II Emp	oloyee Offe	r of Cove	rage		Employee <sup>3</sup>	s Age on J	lanuary 1		Plan Star	rt Month (ei	nter 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)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 C (2000)	

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

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$ |X| $\times$ X |X| $|\times|$ |X|18 Wallace XXX-XX-0780 Lulie |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Katherine Wallace XXX-XX-8476  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X|Harrison Wallace XXX-XX-4564 |X| $\times$ |X||X|X |X||X||X||X|21 Mildred Wallace XXX-XX-6563  $\times$  $\times$  $\times$ X |X|X |X|Elizabeth Wallace XXX-XX-5444 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Carl Watry 8845 Laurel Way Johns Creek, GA 30022

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

CORRECTED

VOID

OMB No. 1545-2251

2023

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

Internal Revenue Se	ervice		Go to www	.irs.gov/For	rs.gov/Form1095C for instructions and the latest information.									
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			<b>8</b> Er	nployer identific	ation number (EIN)	
Carl		Watry			XXX-XX-29	932	W.C. Bradle	ey Co.				581605660		
3 Street address (i	including apartm	ent no.)					9 Street address	ss (including roo	m or suite no.)		<b>10</b> Co	ontact telephone	number	
8845 Laurel V	8845 Laurel Way						PO BOX 14	40				706571	3405	
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province			<b>13</b> Co	13 Country and ZIP or foreign postal code			
Johns Creek	(	GA		US 30	0022		Columbus GA			US	US 31901			
Part II Emp	oloyee Offe	r of Cove	rage	•	Employee'	s Age on J	lanuary 1		Plan Star	rt Month (er	nter 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			Act Notice on						N- 00705M				1005 C (2000)	

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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#### Instructions for Recipient (continued)

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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

Stephen Watson 7221 W Wynfield Loop Midland, GA 31820

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

**CORRECTED** 

VOID

OMB No. 1545-2251

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

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Stephen Watson XXX-XX-9525 581605660 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 7221 W Wynfield Loop **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ US 31820 Midland Columbus GA US 31901 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

# **Instructions for Recipient**

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#### Part I. Applicable Large Employer Member (Employer)

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

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Richard Weeks 1100 N 27th W Ave Tulsa, OK 74127

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

**CORRECTED** 

VOID

OMB No. 1545-2251

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

2023 Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 7 Name of employer 2 Social security number (SSN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) W.C. Bradley Co. Richard Weeks XXX-XX-5806 581605660 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 1100 N 27th W Ave **PO BOX 140** 7065713405 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code OK Tulsa US 74127 Columbus GA US 31901 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A required code) 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.

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John Wells 469 MANOR RIDGEDRIVE ATLANTA, GA 30305

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Form				
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Intern	al Rev	venue	Servi	CA

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

VOID OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	yer)		
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	8 Employer identification number (EIN)		
John		Wells			XXX-XX-7	688	W.C. Bradley Co.					581605660		
3 Street address (i	ncluding apartm	ent no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Cd	ntact telephone	number	
469 MANOR RIDGEDRIVE							PO BOX 1	40				706571	3405	
4 City or town	5	State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code	e 11 City or town 12 State or province			<b>13</b> Co	untry and ZIP or	foreign postal code		
ATLANTA		GΑ		US 30	)305		Columbus GA			US	US 31901			
Part II Emp	oloyee Offe	r of Cove	rage		Employee	's Age on c	January 1		Plan Sta	rt Month (e	enter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			A at Nation and										1005 C (2222	

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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (e) Months of coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN First name, middle initial, last name TIN is not available) all 12 months Aug Jan Feb Mar Apr May June July Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $|\times|$  $\times$ |X|Wells 18 XXX-XX-7688 John  $\times$  $\times$  $\times$  $\times$  $\times$ |X|X  $|\times|$  $\times$ |X|XXX-XX-8077 19 Wendi Wells 20 21 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Mark S Werner 127 West Boundary Road Mequon, WI 53092

Form	I 09:	5-C
Departi	ment of the	Treasury
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# **Employer-Provided Health Insurance Offer and Coverage**

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Sei	rvice		GO tO WWW	.irs.gov/Fori	m 1095C for in	structions ar	ia the latest ir	ntormation.				`		
Part I Emp	oloyee						Α	pplicable L	arge Empl	loyer Meml	ber (Emplo	yer)		
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	er (SSN)	7 Name of emp	ployer	<b>8</b> En	8 Employer identification number (EIN)				
Mark	9	S   Werne	er		XXX-XX-04	432	W.C. Bradl	ey Co.		581605660				
3 Street address (in	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	ntact telephone	number	
127 West Bou	ındary Road	t					PO BOX 1	40				706571	3405	
4 City or town	5	State or provi	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	<b>13</b> Co	untry and ZIP or	foreign postal code	
Mequon	\	NΙ		US 53	US 53092				GA		US	US 31901		
Part II Emp	oloyee Offe	r of Cove	rage	•	Employee <sup>3</sup>	's Age on	January 1		Plan Sta	rt Month (e	nter 2-digit r	2-digit number):		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		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)		2A												
17 ZIP Code													1005.0	

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$ |X| $\times$ |X| $\times$ X |X| $|\times|$ |X|S 18 Werner XXX-XX-0432 Mark X |X| $|\times|$ |X|X  $|\times|$  $\times$ |X|19 **JANET** Α WERNER XXX-XX-3348  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|WERNER NATHANIEL XXX-XX-9586 |X||X||X| $\times$ |X||X|X |X||X||X||X|**JULIANA WERNER** XXX-XX-1323 22 23 24 25 26 27 28 29 30

#### Instructions for Recipient (continued)

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

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

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

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

Anthony M White 33 Lee Road 988 Phenix City, AL 36870

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

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

VOID

OMB No. 1545-2251

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

Anthony M White XXX-XX-8524 W.C. Bradley Co. 581605 3 Street address (including apartment no.) 33 Lee Road 988 PO BOX 140 706571: 4 City or town	ternai Revenue Servi	rice		GO LO WWW	ili s.gov/roi	11110930 101 111	su ucuons ar	iu tile latest li	mormation.							
Anthony M White XXX-XX-8524 W.C. Bradley Co. 581605 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone PO BOX 140 706571: 4 City or town 5 State or province AL US 36870 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number): 14 Offer of Coverage (enter required code) 1A	Part I Emplo	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	oyer)			
3 Street address (including apartment no.) 33 Lee Road 988 PO BOX 140 706571: 4 City or town Phenix City AL US 36870 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):  14 Offer of Coverage (enter required code) 15 Employee Required Codely 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)  9 Street address (including room or suite no.) PO BOX 140 706571: 12 State or province 13 Country and ZIP or foreign postal code 11 City or town Columbus GA US 31901 Plan Start Month (enter 2-digit number): Plan Start Month (enter 2-digit number): Nov 14 Offer of Coverage (enter required code) 1A 1	Name of employee	e (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer	8 E	8 Employer identification number (EIN)					
23 Lee Road 988	nthony		√l White			XXX-XX-8!	524	W.C. Bradl	ley Co.		581605660					
4 City or town Phenix City AL US 36870 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1  All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  15 Employee Required Contribution (see instructions)  \$\$ \$	Street address (inc	cluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number			
Phenix City AL US 36870 Columbus GA US 31901  Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):  All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  1A 1	3 Lee Road 98	88						PO BOX 1	40				706571	3405		
Part II Employee Offer of Coverage	City or town	5	State or prov	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	<b>13</b> C	ountry and ZIP or	foreign postal code		
All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov  14 Offer of Coverage (enter required code)  1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1	Phenix City	1	AL		US 36	US 36870				GA		US	US 31901			
14 Offer of Coverage (enter required code)  1A 1	Part II Emplo	oyee Offe	r of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	2-digit number):			
Coverage (enter required code)  1A 1		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
Required Contribution (see instructions) \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	overage (enter		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
Safe Harbor and Other Relief (enter code, if applicable)	equired ontribution (see	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
17 ZIP Code	afe Harbor and ther Relief (enter															
II Zii Gode	ZIP Code															

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

Pa		<b>red Indi</b> loyer pro		ured coverage, check th	ne box and enter th	ne informatio	on for e	each inc	lividual	enrolle					employe	ee. 🗵		-	
	(a) Name o First name, ı	f covered in	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	other (d) Covered (e) Months of coverage													
_	i iist name, i	Tildale iriitia	ii, iast riame		Tilv is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

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

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

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

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

Christopher J White 322 Tulipwood Cir Covington, GA 30016

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

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

CORRECTED

VOID

OMB No. 1545-2251

Department of the Treasury
Internal Revenue Service

Go to www.irs.gov/Form1095C for instruct

2023

internal Revenue Se	rvice		GO IO WW	w.irs.gov/roi	11110950 101	instructions at	ons and the latest information.								
Part I Emp	oloyee						Α	yer)							
1 Name of employ	ee (first name,	middle initial,	last name)	2 Socia	al security num	ber (SSN)	7 Name of emp	ployer			<b>8</b> Em	nployer identific	cation number (EIN)		
Christopher		J Whit	е		XXX-XX-	3569	W.C. Bradl	ey Co.		58160	5660				
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ss (including roc	<b>10</b> Co	10 Contact telephone number					
322 Tulipwood	d Cir						PO BOX 140					7065713405			
4 City or town		5 State or pro	ovince	6 Count	ry and ZIP or fo	reign postal code	11 City or town		12 State or pr	ovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Covington									GA		US :	31901			
Part II Emp	oloyee Off	er of Cov	erage	•	Employe	e's Age on	January 1		Plan Star	t Month (er	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
<b>14</b> Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)								2A	2A	2A	2A	2A	2A		
<b>17</b> ZIP Code															

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

Cat. No. 60705M

## **Instructions for Recipient**

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

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

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

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

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

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

Pa	Irt III Covere			red coverage, check th	ne box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of c			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Christopher	J	White	XXX-XX-3569			$\times$	$\times$	$\times$	$\times$	X	$\times$						
19	Lisa		White	XXX-XX-2802			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$						
20	Rosaline	Н	White	XXX-XX-4980			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$						
21	James	K	White	XXX-XX-8081			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$						
22																		
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#### Instructions for Recipient (continued)

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**Line 17.** This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

#### Part III. Covered Individuals, Lines 18–30

Clare Williams 3107 Peachtree Road NE, Unit 1201 Atlanta, GA 30305

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Internal	Rovenue Sen	/ica

# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	oloyee						А	pplicable L	arge Emp	loyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			<b>8</b> En	nployer identific	ation number (EIN)		
Clare		Willia	ms		XXX-XX-4	427	W.C. Bradl	ley Co.			58160	5660			
3 Street address (i	ncluding apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
3107 Peachtre	ee Road N	E Unit 120	1				PO BOX 1	40				706571	3405		
4 City or town		5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code		
Atlanta		GA		US 30	0305		Columbus		GA		US	31901			
Part II Emp	oloyee Off	er of Cove	rage	•	Employee	's Age on c	January 1		Plan Sta	art Month (e	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 0 2222		

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Cat. No. 60705M

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Cove	red Indivologer prov	<b>/iduals</b> vided self-insur	ed coverage, check th			on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name o First name, i	of covered in middle initial	dividual(s) , last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Clare		Williams	XXX-XX-4427			X	$\times$	X	X	$\times$	X	X	X	X	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

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#### Part III. Covered Individuals, Lines 18–30

Elizabeth Williams 329 Boat Club Way Hamilton, GA 31811

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Form	IU	<b>195</b>	<b>-</b> U
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			<b>8</b> Em	ployer identific	ation number (EIN)		
Elizabeth		Willia			XXX-XX-8	981	W.C. Bradl	ley Co.			58160	5660			
3 Street address (i	including apartr	ment no.)		'			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
329 Boat Club	o Way						PO BOX 1	40				7065713405			
4 City or town		5 State or prov	rince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Hamilton		GA		US 31	1811		Columbus GA					31901			
Part II Emp	oloyee Off	er of Cove	rage	•	Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
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Cat. No. 60705M

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- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere		ed coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o		(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Elizabeth	Williams	XXX-XX-8981			X	×	X	X	×	X	×	X	X	$\boxtimes$	×	$\times$
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#### Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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**Line 17.** This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

#### Part III. Covered Individuals, Lines 18–30

Katherine Wilson 7725 Cartlege Road Box Springs, GA 31801

Form	I 09:	5-C
Departi	ment of the	Treasury
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB No. 1545-2251

epartment of the Treasury

Do not attach to your tax return. Keep for your record to the Treasury

On the union for the Treasury

DRRECTED 2025

Internal Revenue Ser	vice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	nformation.							
Part I Emp	loyee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer	8 En	8 Employer identification number (EIN)					
Katherine Wilson XXX-XX-5256							W.C. Bradl	ey Co.				581605660			
3 Street address (including apartment no.)							9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Cd	10 Contact telephone number			
7725 Cartlege	Road						PO BOX 1	40				7065713405			
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or	province	<b>13</b> Co	untry and ZIP or	foreign postal code		
Box Springs		GΑ		US 31	1801		Columbus		GA		US	US 31901			
Part II Emp	loyee Offe	r of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit i	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			Act Nation on						N- 00705M				1005 € (2000)		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit *www.irs.gov/ACA* or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

#### Part I. Employee

Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

#### Part I. Applicable Large Employer Member (Employer)

**Lines 7–13.** Part I, lines 7 through 13, reports information about your employer.

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

### Part II. Employer Offer of Coverage, Lines 14–17

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere	ed Indi	<b>ividuals</b> ovided self-insur	ed coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o	covered i ddle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Katherine		Wilson	XXX-XX-5256	,		X	×	X	X	×	X	×	X	X	×	X	X
19	RONNIE		WILSON	XXX-XX-7340			$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$	$\times$
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#### Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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**Line 17.** This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

#### Part III. Covered Individuals, Lines 18–30

Jeremy Winder 76 Brooks Road Phenix City, AL 36870

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Form	I U95-	-U								
Department of the Treasury										
Internal	Rovenue Sen	/ica								

# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Applicable Large Employer Member (Employer)									
1 Name of employe	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer	<b>8</b> En	8 Employer identification number (EIN)						
Jeremy		Winde	er		XXX-XX-90	)55	W.C. Bradl	ey Co.				581605660				
3 Street address (in	3 Street address (including apartment no.)								m or suite no.)		<b>10</b> Cd	10 Contact telephone number				
76 Brooks Roa	ad						PO BOX 14	40				7065713405				
4 City or town 5 State or province					ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	<b>13</b> Co	untry and ZIP or f	foreign postal code			
Phenix City AL				US 36	870		Columbus		GA		US	US 31901				
Part II Emp	loyee Offe	er of Cove	rage	·	Employee'	s Age on	January 1		Plan Star	<b>t Month</b> (er	ter 2-digit r	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	1H	1H	1H	1H	1H	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)						2A	2A	2A	2A	2A	2A	2A	2A			
17 ZIP Code													100E C (2000			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

## **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
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- 1Z. Reserved for future use.

Pa	I <b>rt III</b> Cover If Empl	ed Indivoyer prov	<b>/iduals</b> /ided self-insure	ed coverage, check th	e box and enter th	e informatio	on for e	each inc	lividual	enrolle					mploye	ee. 🗵		
	(a) Name of First name, n	covered in	dividual(s) . last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	e) Months of coverage  June July Aug			Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

#### Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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#### Part III. Covered Individuals, Lines 18–30