Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

► Do not attach to your tax return. Keep for your records.
► Go to *www.irs.gov/form1095C* for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2018

Part I Employee

2 Social security number (SSN): XXX-XX-9384

Applicable Large Employer Member (Employer)

8 Employer identification number: 42-0127290

1 Name of employee - First name, middle initial, last name: ANTONY | ROSS

7 Name of employer: PRINCIPAL FINANCIAL GROUP INC.

3 Street address (including apartment no.): 5485 E NORWICH AVE

9 Street address (including room or suite no.): 711 HIGH STREET

10 Contact telephone number: 1-855-406-9236

4 City or town: FRESNO | 5 State or province: CA | 6 Country and ZIP or foreign postal code: US 93727-7151

11 City or town: DES MOINES | 12 State or province: IA | 13 Country and ZIP or foreign: US 50392

Part II Employee Offer of Coverage

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)		1H	1H	1H	1E	1E	1E	1E	1E	1E	1H	1H	
15 Employee Required Contribution (see instructions)	$	$	$	$	$ 162.09	$ 162.09	$ 162.09	$ 162.09	$ 162.09	$ 162.09	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2F	2F	2F	2F	2F	2F	2A	2A	

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

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc
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18														
19														
20														
21														

Name of employee (first name, middle initial, last name): ANTONY | ROSS

Social security number (SSN): XXX-XX-9384

Part III Covered Individuals – Continuation Sheet

	(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	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc
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