600118

Depa	1095 Introduction of the Theal Revenue Se	reasury	Employer-Provided Health Insurance ► Do not attach to your tax return. Keep f ► Go to www.irs.gov/Form1095C for instructions a								for your records.						CTED		OMB No. 1545-2251			
-	art Emp				00101010	v.ii 3.90v/i							arge	Emplo	ver Me	ember	(Emp	lover)				
1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)								7 Name of employer								8 Employer identification number (EIN)						
3 Street address (including apartment no.)										9 Street address (including room or suite no.)							10 Contact telephone number					
4 City or town 5 State or pro				province		6 Cou	Country and ZIP or foreign postal code			11 City or town 12 State or pro				vince			13 Country and ZIP or foreign postal code					
Pa	rt II Emp	ployee Of	fer of Co	verag	е				Pla	an Sta	art Mo	nth (ent	er 2-di	git num	ber):							
All 12 Months					Feb	Mar	Apr	May	1	June	· · · · · · · · · · · · · · · · · · ·		A	Aug		ot	Oct		Nov	[Dec	
14 Offer of Coverage (enter required code)																						
15 Employee Required Contribution (see instructions)		\$	\$\$			\$	\$	\$	\$		\$		\$		\$		\$		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																						
Pa		vered Indi nployer pro		-insured	d coverage	, check tl	he box and ent	er the inform	natic	on for e	each ind	dividual	enrolle				-	employ	ee.			
		e of covered in e, middle initia				other TIN	(c) DOB (if SSN or TIN is not availa						•	(e) Months of Cove			ř <u> </u>					
	Tilotilaine								11113	Jan	Feb	Mar	Apr	Мау	June	July	Aug	Sept	Oct	Nov	Dec	
17]													
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