

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.

VOID

CORRECTED

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee George Washington			2 Social security number (SSN) 111-11-1111			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 1234 American Drive						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Richmond		5 State or province VA		6 Country and ZIP or foreign postal code 45678		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) 1E													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage \$ 100	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable) 2C													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 George Washington	111-11-1111		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Martha Washington	111-11-1112		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exemple 1-B

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

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.

VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee George Washington			2 Social security number (SSN) 111-11-1111			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 1234 American Drive						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Richmond		5 State or province VA		6 Country and ZIP or foreign postal code 45678		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 110	\$ 110	\$ 110	\$ 110	\$ 110	\$ 110
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 George Washington	111-11-1111		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Martha Washington	111-11-1112		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

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VOID

CORRECTED

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee Bugs Bunny			2 Social security number (SSN) 222-22-2222			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 234 Carrot Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Albuquerque		5 State or province NM		6 Country and ZIP or foreign postal code 78901		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 100	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2H												

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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VOID

600115

OMB No. 1545-2251

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2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee Bugs Bunny			2 Social security number (SSN) 222-22-2222			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 234 Carrot Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Albuquerque		5 State or province NM		6 Country and ZIP or foreign postal code 78901		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 108.33	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2F												

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

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VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee Bugs Bunny			2 Social security number (SSN) 222-22-2222			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 234 Carrot Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Albuquerque		5 State or province NM		6 Country and ZIP or foreign postal code 78901		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 100	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Bugs Bunny	222-22-2222		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18 Lola Bunny	221-22-2222		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

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VOID

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OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee John Doe			2 Social security number (SSN) 123-45-6789			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 555 Normal Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Boring		5 State or province MI		6 Country and ZIP or foreign postal code 49806		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	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	1E	1E	1E	1E	1E	1E
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	100	100	100	100	100	100
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2A	2A	2A	2D	2D	2D	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage												
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17 John Doe	123-45-6789		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

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VOID

CORRECTED

Part I Employee						Applicable Large Employer Member (Employer)						
1 Name of employee John Doe			2 Social security number (SSN) 123-45-6789			7 Name of employer ABC Mfg. Company				8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 555 Normal Lane						9 Street address (including room or suite no.) 100 Alphabet Lane				10 Contact telephone number 800-555-0199		
4 City or town Boring		5 State or province MI		6 Country and ZIP or foreign postal code 49806		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503		

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
			1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2D	2D	2D	2D	2C	2C	2C	2C	2C	2C	2C	2C

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 John Doe	123-45-6789		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee John Doe			2 Social security number (SSN) 123-45-6789			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 555 Normal Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Boring		5 State or province MI		6 Country and ZIP or foreign postal code 49806		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	1H											
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
		2A	2A	2D	2B	2B					2B	2B	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c.

VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee John Doe			2 Social security number (SSN) 123-45-6789			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 555 Normal Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Boring		5 State or province MI		6 Country and ZIP or foreign postal code 49806		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	1H											
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
		2A	2A	2A	2A	2D				2A	2A	2A	2A

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c.

VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee John Doe			2 Social security number (SSN) 123-45-6789			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 555 Normal Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Boring		5 State or province MI		6 Country and ZIP or foreign postal code 49806		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	1H											
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	2A	2A	2A	2A	2A	2D	2D	2D	2D	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Example 5

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

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c.

VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee Jane Smith			2 Social security number (SSN) 111-11-1111			7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567		
3 Street address (including apartment no.) 111 Anywhere Lane						9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199		
4 City or town Grand Rapids		5 State or province MI		6 Country and ZIP or foreign postal code 49503		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2A	2E	2E	2E	2E	2E	2E	2E	2E	2E	2E	2E

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c.

VOID

CORRECTED

Part I Employee						Applicable Large Employer Member (Employer)							
1 Name of employee Gerald Ford		2 Social security number (SSN) 333-33-3333		7 Name of employer ABC Mfg. Company				8 Employer identification number (EIN) 20-1234567					
3 Street address (including apartment no.) 1955 University Drive						9 Street address (including room or suite no.) 100 Alphabet Lane				10 Contact telephone number 800-555-0199			
4 City or town Ann Arbor		5 State or province MI		6 Country and ZIP or foreign postal code 48111		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503			

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C	2C	2C	2C	2C	2C	2C	2C	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage												
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17 Gerald Ford	333-33-3333		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Betty Ford	333-33-3331		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c.

VOID

CORRECTED

Part I Employee						Applicable Large Employer Member (Employer)							
1 Name of employee Gerald Ford			2 Social security number (SSN) 333-33-3333			7 Name of employer ABC Mfg. Company				8 Employer identification number (EIN) 20-1234567			
3 Street address (including apartment no.) 1955 University Drive						9 Street address (including room or suite no.) 100 Alphabet Lane				10 Contact telephone number 800-555-0199			
4 City or town Ann Arbor		5 State or province MI		6 Country and ZIP or foreign postal code 48111		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503			

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1E	1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C	2C	2C	2C	2C	2C	2C	2C	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage												
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17 Gerald Ford	333-33-3333		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Betty Ford	333-33-3331		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Example 6-B

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

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.

VOID

600115

OMB No. 1545-2251

CORRECTED

2014

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee Gerald Ford		2 Social security number (SSN) 333-33-3333		7 Name of employer ABC Mfg. Company			8 Employer identification number (EIN) 20-1234567				
3 Street address (including apartment no.) 1955 University Drive				9 Street address (including room or suite no.) 100 Alphabet Lane			10 Contact telephone number 800-555-0199				
4 City or town Ann Arbor		5 State or province MI		6 Country and ZIP or foreign postal code 48111		11 City or town Grand Rapids		12 State or province MI		13 Country and ZIP or foreign postal code 49503	

Part II Employee Offer and Coverage													
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100?	\$ 500	\$ 500	\$ 500	\$ 500
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17 Gerald Ford	333-33-3333		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Betty Ford	333-33-3331		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

► Information about Form 1094-C and its separate instructions is at www.irs.gov/f1094c.

CORRECTED

120115
OMB No. 1545-2251

2014

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer) ABC Mfg. Company		2 Employer identification number (EIN) 20-1234567
3 Street address (including room or suite no.) 100 Alphabet Lane		
4 City or town Grand Rapids	5 State or province MI	6 Country and ZIP or foreign postal code 49503
7 Name of person to contact Jay Smith		8 Contact telephone number 800-555-0199
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

For Official Use Only



17 Reserved

18 Total number of Forms 1095-C submitted with this transmittal ► 150

Part II ALE Member Information

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member ► 150

21 Is ALE Member a member of an Aggregated ALE Group? Yes No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

A. Qualifying Offer Method B. Qualifying Offer Method Transition Relief C. Section 4980H Transition Relief D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature: Jay Smith Title: Chief Financial Officer Date: 2/25/16

Part III ALE Member Information – Monthly

	(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
	Yes	No				
23 All 12 Months	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input checked="" type="checkbox"/>	B
24 Jan	<input type="checkbox"/>	<input type="checkbox"/>	140	175	<input type="checkbox"/>	
25 Feb	<input type="checkbox"/>	<input type="checkbox"/>	140	174	<input type="checkbox"/>	
26 Mar	<input type="checkbox"/>	<input type="checkbox"/>	140	178	<input type="checkbox"/>	
27 Apr	<input type="checkbox"/>	<input type="checkbox"/>	140	177	<input type="checkbox"/>	
28 May	<input type="checkbox"/>	<input type="checkbox"/>	140	179	<input type="checkbox"/>	
29 June	<input type="checkbox"/>	<input type="checkbox"/>	141	179	<input type="checkbox"/>	
30 July	<input type="checkbox"/>	<input type="checkbox"/>	141	178	<input type="checkbox"/>	
31 Aug	<input type="checkbox"/>	<input type="checkbox"/>	141	177	<input type="checkbox"/>	
32 Sept	<input type="checkbox"/>	<input type="checkbox"/>	141	177	<input type="checkbox"/>	
33 Oct	<input type="checkbox"/>	<input type="checkbox"/>	142	178	<input type="checkbox"/>	
34 Nov	<input type="checkbox"/>	<input type="checkbox"/>	142	178	<input type="checkbox"/>	
35 Dec	<input type="checkbox"/>	<input type="checkbox"/>	142	179	<input type="checkbox"/>	

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

Name	EIN	Name	EIN
36 XYZ Corporation	11-1111111	51	
37 L&M Company	11-111112	52	
38		53	
39		54	
40		55	
41		56	
42		57	
43		58	
44		59	
45		60	
46		61	
47		62	
48		63	
49		64	
50		65	