

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

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

VOID

CORRECTED

OMB No. 1545-2251

**2021**

Part I Employee				Applicable Large Employer Member (Employer)					
1 Name of employee (first name, middle initial, last name) Kris Q Public		2 Social security number (SSN) xxx-xx-1234		7 Name of employer Tax Form Issuer, Inc			8 Employer identification number (EIN) 12-3456789		
3 Street address (including apartment no.) 1 Main St				9 Street address (including room or suite no.) 12021 Sunset Valley Dr			10 Contact telephone number 888-555-1212		
4 City or town Melrose		5 State or province NY		6 Country and ZIP or foreign postal code 12121		11 City or town Preston		12 State or province VA	13 Country and ZIP or foreign postal code 20191

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	Dec		
14 Offer of Coverage (enter required code) 1E														1E	1E
15 Employee Required Contribution (see instructions) \$ 30.18	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 15.09	\$ 15.09
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C														2C	2C
17 ZIP Code															