Line 14 - Employer's offer of Coverage. Common Codes are:

- **1E** – Minimum essential coverage offered to Spouse & Dependents
- **1G** – Offer of coverage to a Part-time employee
- **1H** – No Offer of coverage.

Line 15 – Employee's lowest cost premium for self-coverage.

- Single coverage on plan 3
- Minimum Value plan.

Line 16 – explains if the employee enrolled/waived, and if line 15 meets affordability. Common Codes are:

- **2C** – enrolled in coverage **every day** of calendar month.
- **2A** – Not an employee for **any** day of calendar month
- **2I** – Non-calendar year transitional relief.
- **2D** – Limited Non – Assessment period. For new employee's in initial measurement period
- **2B** – enrolled in coverage, but not an employee for entire month
- **2G** – Employee Waived coverage, that was affordable to them
- **Blank** – Employer did not meet affordability in line 15.

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/form1095c*

☐ VOID ☐ CORRECTED

600116

OMB No. 1545-2251

2015

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province / 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town / 12 State or province	13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

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)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2015)

Part III Covered Individuals (Lines 17 – 22)

- Individual mandate
- Shows all individuals covered under the employee's plan, like your spouse or dependents
- Marks every month that the employee enrolled in coverage. (Full Month)