

Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.

Go to [www.irs.gov/Form1095C](https://www.irs.gov/Form1095C) for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2024

600120

Part I Employee						Applicable Large Employer Member (Employer)							
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 province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code			
Part II Employee Offer of Coverage					Employee's Age on January 1				Plan Start Month (enter 2-digit number):				
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													