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

Employer-Provided Health Insurance Offer and Coverage

▸ Do not attach to your tax return. Keep for your records.
▸ Information about Form 1095-C and its separate instructions is at *www.irs.gov/f1095c*.

☐ VOID
☐ CORRECTED

600118
OMB No. 1545-2251
2018

Part I Employee

1 Name of employee	2 Social security number (SSN)
Employee Smith	XXX-XX-1234
3 Street address (including apartment no.)	
123 Maple Drive Unit 2	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
Amana	IA	52203

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
State of Iowa - Centralized Payroll	XX-XXXXXXX
9 Street address (including room or suite no.)	**10** Contact telephone number
1305 East Walnut St.	
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
Des Moines	IA	50319- USA

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)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	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 individual enrolled in coverage, including the employee. X

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN 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	Employee Smith	XXX-XX-1234			X	X	X	X	X	X	X	X	X	X	X	X
18	Spouse Smith	XXX-XX-2345			X	X	X	X	X	X	X	X	X	X	X	X
19	Child Smith	XXX-XX-3456											X	X	X	X
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