

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.

Go to www.irs.gov/Form1095C for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

2025

Part I Employee					Applicable Large Employer Member (Employer)																																																																																				
1 Name of employee (first name, middle initial, last name) 1.40 in			2 Social security number (SSN) 1.40 in		7 Name of employer 1.80 in					8 Employer identification number (EIN) .33 in																																																																															
3 Street address (including apartment no.) 5 in							9 Street address (including room or suite no.)					10 Contact telephone number																																																																													
4 City or town 1.50 in			5 State or province 1.70 in		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) .70 in					All 12 Months					Jan					Feb .33 in					Mar					Apr					May					June					July					Aug					Sept					Oct					Nov					Dec																								
15 Employee Required Contribution (see instructions) .50 in					\$					\$					\$					\$					\$					\$					\$					\$					\$					\$					\$					\$																													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																																																																																									
17 ZIP Code .50 in																																																																																									

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2025) Created 5/21/25

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.17 in

Part I Employee

1 Name of employee (first name, middle initial, last name) 1.40 in		2 Social security number (SSN) 1.80 in	
3 Street address (including apartment no.) 5 in			
4 City or town 1.50 in		5 State or province 1.70 in	
6 Country and ZIP or foreign postal code			

Applicable Large Employer Member (Employer)

7 Name of employer .33 in		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

.90 in

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) .70 in			.33 in										
15 Employee Required Contribution (see instructions) .50 in	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													

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Part I Employee

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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 of Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code) .70 in			.33 in										
15 Employee Required Contribution (see instructions) .50 in	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code .50 in													

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