

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

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

Go to www.irs.gov/Form1095B for instructions and the latest information.

☐ VOID

☒ CORRECTED

OMB No. 1545-2252

2026

Part I Responsible Individual

1 Name of responsible individual—First name, middle name, last name Vicky		2 Social security number (SSN) or other TIN 000000211	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 2255 Oak Avenue	5 City or town Dublin	6 State or province OH	7 Country and ZIP or foreign postal code 43016
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): A		9 Reserved	

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name Workshoptwo		11 Employer identification number (EIN) 000000250	
12 Street address (including room or suite no.) 1095 Cedar Lane	13 City or town Westerville	14 State or province OH	15 Country and ZIP or foreign postal code 43081

Part III Issuer or Other Coverage Provider (see instructions)

16 Name Hidetestone		17 Employer identification number (EIN) 000000151	18 Contact telephone number 5555550001
19 Street address (including room or suite no.) 2277 Holly Place	20 City or town Washington	21 State or province DC	22 Country and ZIP or foreign postal code 20022

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s) First name, middle initial, last name	(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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
23 Vicky	Willhelm	000000211	☐	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐	☐
24 Fred	Willhelm	000000212	☐	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐	☐
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Name of responsible individual—First name, middle name, last name	Social security number (SSN) or other TIN	Date of birth (if SSN or other TIN is not available)
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Part IV Covered Individuals — Continuation Sheet

(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
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