☐ VOID   ☐ CORRECTED   OMB No. 1545-2251   **2018**   Form **1095-C**   **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town state or province, country, ZIP or foreign postal code, and telephone no.

CITY GOVERNMENT NAME
11000 BRIDGE STREET
PO BOX 999
ANYTOWN CT 06000
8602223333

Information about Form 1095-C and its separate Instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, street address, ZIP/postal code & country

RICHARD T EMPLOYEE
P. O. BOX 99
SOUTH MAIN STREET
ANYTOWN CT 062233

APPLICABLE LARGE EMPLOYER'S Identification number (EIN)	EMPLOYEE'S social security number (SSN)
999999999	000-11-2222

Employee Offer and Coverage

Plan Start Mo.(Enter 2-digit no.): 07	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)
All 12 Months		$	2C
Jan	1A	$	
Feb	1A	$	
Mar	1A	$	
Apr	1A	$	
May	1A	$	
Jun	1A	$	
Jul	1E	$ 96.70	
Aug	1E	$ 96.70	
Sep	1E	$ 96.70	
Oct	1E	$ 96.70	
Nov	1E	$ 96.70	
Dec	1E	$ 96.70	

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 mos.	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17	LOUISE B EMPLOYEE	000-11-2222	09/12/1950		X	X	X	X	X	X	X	X	X	X	X	X
18	RICHARD I EMPLOYEE	000-22-4444	06/22/1953	X												
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