employer-level data for the employer, check the box on line 19 and continue completing Part II.

There must be only one Authoritative Transmittal filed for each employer. If only one Form 1094-C is being filed for the employer, that Form 1094-C must report aggregate employer-level data for the employer and be identified on line 19 as the Authoritative Transmittal. If multiple Forms 1094-C are being filed for an employer so that Forms 1095-C for all full-time employees of the employer are not attached to this transmittal (because Forms 1095-C for some full-time employees of the employer are being transmitted separately), one of the Forms 1094-C must report aggregate employer-level data for the employer and be identified on line 19 as the Authoritative Transmittal.

**Note.** Lines 20–22 should be completed only on the Authoritative Transmittal for the employer. For more information, see *Authoritative Transmittal for Employees Filing Multiple Forms 1094-C*, earlier. If this is not the Authoritative Transmittal for the employer, do not complete lines 20–22, Parts III or IV. Sign Form 1094-C.

**Line 20.** Enter the total number of Forms 1095-C that will be filed by and/or on behalf of the employer. This includes Forms 1095-C for the employer's full-time employees that are filed with this transmittal, those that will be filed with another transmittal filed by or on behalf of the employer, and Forms 1095-C filed for non-full-time employees who enroll in the employer's employer-sponsored self-insured health plan.

**Line 21.** If during any month of the calendar year the employer was a member of an Aggregated ALE Group, check "Yes." If you check "Yes," you must also complete the "Aggregated Group Indicator" in Part III, column (d), and Part IV to list the other members of the Aggregated ALE Group. If, for all 12 months of the calendar year, the employer was not a member of an Aggregated ALE Group, check "No," and do not complete Part III, column (d), or Part IV.

**Line 22.** If the employer meets the eligibility requirements and is using one of the Offer Methods and/or one of the forms of Transition Relief indicated, it must check each applicable box. See the description of the *Offer Methods* and *Section 4980H Transition Relief*, later.

**Note.** For 2014, Forms 1094-C and 1095-C are not required to be filed by any employer, and no employer shared responsibility payment will apply for 2014 for any employer.

***A. Qualifying Offer Method.*** Check this box if the employer is eligible to use and is using the Qualifying Offer Method for one or more full-time employees. To be eligible to use the Qualifying Offer Method, the employer must certify that, for all months during the year in which the employee was a full-time employee for whom a section 4980H employer shared responsibility payment could apply, the employer made a Qualifying Offer.

If the employer uses this method, it must not provide on Form 1095-C, line 15, the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value. It instead must use the Qualifying Offer code 1A on Form 1095-C, line 14, to indicate that the employee received a Qualifying Offer for all 12 months. Use of this method is optional and an employer may, rather than report using this method and the Qualifying Offer code 1A , report on line 14 the applicable offer code and on line 15 the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value for that month. An employer may not, for any month, use code 1A and also report the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value.


*If the employer is eligible to use the Qualifying Offer Method, it may use the Qualifying Offer code 1A for any month for which it made a Qualifying Offer to an employee, even if the employee did not receive a Qualifying Offer for all 12 months. However, the employer must furnish a copy of Form 1095-C to any employee who did not receive a Qualifying Offer for all 12 months, unless the Qualifying Offer Method Transition Relief applies.*

***Alternative Method of Furnishing to Employees under the Qualifying Offer Method.*** An employer that is eligible to use the Qualifying Offer Method meets the requirement to furnish the Form 1095-C to its full-time employees who received a Qualifying Offer for all 12 months of the calendar year if it furnishes each of those full-time employees either a copy of Form 1095-C as filed with the IRS or a statement containing the following information.

- Employer name, address, and EIN.
- Contact name and telephone number.
- A statement indicating that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit. See Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

***B. 2015 Qualifying Offer Method Transition Relief.*** Check this box if the employer is eligible for and is using the Qualifying Offer Method Transition Relief for 2015. For the 2015 calendar year, to be eligible to use the Qualifying Offer Method Transition Relief the employer must certify that it made a Qualifying Offer for one or more months of calendar year 2015 to at least 95% of its full-time employees.

If an employer uses this method, it must not provide on Form 1095-C, line 15, the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value and instead must use either the Qualifying Offer code 1A or the Qualifying Offer Method Transition Relief code 1I on Form 1095-C, line 14, to indicate the months in 2015 for which the employer is eligible for the Qualifying Offer Method Transition Relief code 1I or the months for which the employee received a Qualifying Offer code 1A. For any months for which the employee received a Qualifying Offer, the employer must report using the Qualifying Offer code 1A to indicate that the employee received a Qualifying Offer for that month. For any month, use of this method is optional, and an employer may, rather than report using this method and the Qualifying Offer code 1A or the Qualifying Offer Method Transition Relief code 1I, report on line 14 the

applicable offer code and on line 15 the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value for that month. An employer may not, for any month, use code 1A or code 1I and also report the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value.

***Alternative Furnishing Methods Under the Qualifying Offer Method Transition Relief for 2015.*** Solely for 2015, for any employee of an employer eligible for the Qualifying Offer Method Transition Relief who does not receive a Qualifying Offer for all 12 calendar months, including employees who receive no offer, the employer may, in lieu of providing the employee with a copy of Form 1095-C, furnish a statement containing the following information.

- Employer name, address, and EIN.
- Contact name and telephone number.
- A statement indicating that the employee and his or her spouse and dependents, if any, may be eligible for a premium tax credit for one or more months of 2015.

See Pub. 974 for more information on eligibility for the premium tax credit.

An employer that is eligible for the Qualifying Offer Method Transition Relief for any employee who receives a Qualifying Offer for all 12 months of the calendar year may, in lieu of furnishing the employee a copy of Form 1095-C, furnish a statement as described in *Alternative Method of Furnishing to Employees Under the Qualifying Offer Method*, earlier.

***C. Section 4980H Transition Relief.*** Check this box if either (1) 2015 Section 4980H Transition Relief for ALEs with Fewer Than 100 Full-Time Employees, Including Full-Time Equivalent Employees (50-99 Transition Relief) or (2) 2015 Transition Relief for Calculation of Assessable Payments Under Section 4980H(a) for ALEs with 100 or More Full-Time Employees, Including Full-Time Equivalent Employees (100 or More Transition Relief) apply. For a description of the relief, including which employers are eligible for the relief, see *Section 4980H Transition Relief for 2015*, later. If an employer checks this box, it must also complete Form 1094-C, Part III, column (e), Section 4980H Transition Relief Indicator, to indicate the type of section 4980H transition relief for which it is eligible.

***D. 98% Offer Method.*** Select this box if the employer is eligible for and is using the 98% Offer Method. To be eligible to use the 98% Offer Method, an employer must certify that it offered, for all months of the calendar year, affordable health coverage providing minimum value to at least 98% of its employees and their dependents for whom it is filing a Form 1095-C employee statement. The employer is not required to identify which of the employees for whom it is filing were full-time employees, but the employer is still required to file Forms 1095-C on behalf of all of its full-time employees. (For this purpose, the health coverage is affordable if the employer meets one of the section 4980H affordability safe harbors.)

**Note.** If an employer uses this method, it is not required to complete the "Full-Time Employee Count" in Part III, column (b).

## Part III—ALE Member Information—Monthly (Line 23-35)

**Column (a) Minimum Essential Coverage Offer Indicator.** If the employer offered minimum essential coverage under an eligible employer-sponsored plan to at least 95% of its full-time employees and their dependents for the entire calendar year, enter "X" in the "Yes" checkbox on line 23 for "All 12 Months". If the employer offered minimum essential coverage to at least 95% of its full-time employees and their dependents only for certain calendar months, enter "X" in the "Yes" checkbox for each applicable month. For the months, if any, for which the employer did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents, enter "X" in the "No" checkbox for each applicable month, or enter "X" in the "All 12 Months" box on line 23 if the employer did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents for any of the 12 months. However, an employer that did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents but is entitled to certain transition relief described in the instructions later under *Section 4980H Transition Relief for 2015* should enter an "X" in the "Yes" checkbox for Part III, line 23, column (a), as applicable. See the instructions later under *Section 4980H Transition Relief for 2015*.

**Note.** For purposes of column (a), an employee in a Limited Non-Assessment Period is not counted in determining whether minimum essential coverage was offered to at least 95% of an employer's full-time employees and their dependents.


*For purposes of column (a), if the employer offered minimum essential coverage to all but five of its full-time employees and their dependents, and if five is greater than 5% of the number of full-time employees of the employer, the employer may report in column (a) as if it offered health coverage to at least 95% of its full-time employees and their dependents (even if it offered health coverage to less than 95% of its full-time employees and their dependents, for example to 75 of its 80 full-time employees and their dependents).*

See *Definitions*, later, for more information on an offer of health coverage.

**Column (b) Full-Time Employee Count for ALE Member.** Enter the number of full-time employees for each month, but do not include any employee in a Limited Non-Assessment Period. (If the number of full-time employees (excluding employees in a Limited Non-Assessment Period) for a month is zero, enter 0.)

**Note.** If the employer certified that it was eligible for the 98% Offer Method by selecting box D, on line 22, it is not required to complete column (b).

**Column (c) Total Employee Count for ALE Member.** Enter the total number of employees, including full-time employees and non-full-time employees, for each calendar month. An employer must choose to use either the first day of each month or the last day of each month to determine the number of employees per month and must use the same day (first or last day of the month) for

Form **1094-C**

Department of the Treasury
Internal Revenue Service

# Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ **Information about Form 1094-C and its separate instructions is at *www.irs.gov/f1094c.***

☐ CORRECTED

120115

OMB No. 1545-2251

**2014**

## Part I Applicable Large Employer Member (ALE Member)

| | | |
|---|---|---|
| **1** Name of ALE Member (Employer) | | **2** Employer identification number (EIN) |
| **3** Street address (including room or suite no.) | | |
| **4** City or town | **5** State or province | **6** Country and ZIP or foreign postal code |
| **7** Name of person to contact | | **8** Contact telephone number |
| **9** Name of Designated Government Entity (only if applicable) | | **10** Employer identification number (EIN) |
| **11** Street address (including room or suite no.) | | |
| **12** City or town | **13** State or province | **14** Country and ZIP or foreign postal code |
| **15** Name of person to contact | | **16** Contact telephone number |

**For Official Use Only**

**17** Reserved . . . . . ☐

**18** Total number of Forms 1095-C submitted with this transmittal . . . . . ▶

## Part II ALE Member Information

**19** Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

**20** Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

**21** Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ **Yes** ☐ **No**

If "No," do not complete Part IV.

**22 Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

**Part III ALE Member Information—Monthly**

| | | (a) Minimum Essential Coverage Offer Indicator | | (b) Full-Time Employee Count for ALE Member | (c) Total Employee Count for ALE Member | (d) Aggregated Group Indicator | (e) Section 4980H Transition Relief Indicator |
|---|---|---|---|---|---|---|---|
| | | Yes | No | | | | |
| **23** | All 12 Months | ☐ | ☐ | | | ☐ | |
| **24** | Jan | ☐ | ☐ | | | ☐ | |
| **25** | Feb | ☐ | ☐ | | | ☐ | |
| **26** | Mar | ☐ | ☐ | | | ☐ | |
| **27** | Apr | ☐ | ☐ | | | ☐ | |
| **28** | May | ☐ | ☐ | | | ☐ | |
| **29** | June | ☐ | ☐ | | | ☐ | |
| **30** | July | ☐ | ☐ | | | ☐ | |
| **31** | Aug | ☐ | ☐ | | | ☐ | |
| **32** | Sept | ☐ | ☐ | | | ☐ | |
| **33** | Oct | ☐ | ☐ | | | ☐ | |
| **34** | Nov | ☐ | ☐ | | | ☐ | |
| **35** | Dec | ☐ | ☐ | | | ☐ | |

**Part IV** **Other ALE Members of Aggregated ALE Group**

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

| | Name | EIN | | Name | EIN |
|---|---|---|---|---|---|
| 36 | | | 51 | | |
| 37 | | | 52 | | |
| 38 | | | 53 | | |
| 39 | | | 54 | | |
| 40 | | | 55 | | |
| 41 | | | 56 | | |
| 42 | | | 57 | | |
| 43 | | | 58 | | |
| 44 | | | 59 | | |
| 45 | | | 60 | | |
| 46 | | | 61 | | |
| 47 | | | 62 | | |
| 48 | | | 63 | | |
| 49 | | | 64 | | |
| 50 | | | 65 | | |

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

# Employer-Provided Health Insurance Offer and Coverage

► **Information about Form 1095-C and its separate instructions is at *www.irs.gov/f1095c.***

☐ VOID
☐ CORRECTED

600115
OMB No. 1545-2251
**2014**

## Part I Employee

| 1 Name of employee | 2 Social security number (SSN) |
|---|---|
| 3 Street address (including apartment no.) | |
| 4 City or town | 5 State or province / 6 Country and ZIP or foreign postal code |

## Applicable Large Employer Member (Employer)

| 7 Name of employer | 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 |

## Part II Employee Offer and Coverage

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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) | | | | | | | | | | | | | |

## Part III 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 months | (e) Months of Coverage | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| 17 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Instructions for Recipient

This Form 1095-C includes information about the health coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information needed to report on your income tax return that you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, the issuer of the insurance or the sponsor of the plan providing the coverage will furnish you information about the coverage separately on Form 1095-B. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, the provider of that coverage will furnish you information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A.

**TIP** *Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.*

### Part I. Employee

**Lines 1–6.** Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

**CAUTION** *If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision.*

### Part I. Applicable Large Employer Member (Employer)

**Lines 7–13.** Part I, lines 7–13, reports information about your employer.

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

### Part II. Employer Offer and Coverage, Lines 14–16

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to your or your spouse's and dependents' eligibility for coverage subsidized by the premium tax credit. For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than $1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box on line 14.

**1H**. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. Line 15 will show an amount only if the minimum essential coverage your employer offered provided minimum value. Also, line 15 will be blank if code 1A or code 1I is reported on line 14.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17–22

Part III reports the name, social security number, and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.