

Part III ISSUER'S or OTHER COVERAGE PROVIDER (see instructions) name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ISSUER'S or OTHER COVERAGE PROVIDER'S identification number (EIN)

Health Coverage

Part II Information About Certain Employer-Sponsored Coverage (see instructions) EMPLOYER'S name, address, ZIP/postal code & country

Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095B for instructions and the latest information.

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

Part I RESPONSIBLE INDIVIDUAL'S name, address, ZIP/postal code & country

EMPLOYER'S identification number (EIN)

Enter letter identifying Origin of the Health Coverage (see instructions for codes):

RESPONSIBLE INDIVIDUAL'S social security number (SSN) or other TIN

RESPONSIBLE INDIVIDUAL'S date of birth (if SSN or other TIN is not available)

Reserved

Department of the Treasury -- IRS

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

(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 mos.	(e) Months of coverage																
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First-Class Mail
Important Tax Return
Document Enclosed

SEE REVERSE SIDE FOR
OPENING INSTRUCTIONS

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