



# *Form 1095-C Examples*

*Revised October 3, 2018*



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 1 - Full time & participating all year

#### Key Points in the Scenario

- Suzy Smith is a full time employee working for School District ABC, a large district participating in VEHI.
- Suzy is offered coverage and her spouse and dependents are eligible for the plan.
- Suzy participated in family coverage for the entire year.
- The employee contribution for employee-only coverage in the lowest cost plan available to Suzy is \$50.00 per month, and coverage is affordable based on “rate of pay” safe harbor.

#### Completing the 1095-C

Draft July 24, 2018 <b>Form 1095-C</b> Department of the Treasury Internal Revenue Service		<b>Employer-Provided Health Insurance Offer and Coverage</b> Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.						<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED		OMB No. 1545-2251 <b>2018</b>								
<b>Part I Employee</b>						<b>Applicable Large Employer Member (Employer)</b>												
1 Name of employee (first name, middle initial, last name) Suzy B Smith			2 Social security number (SSN) 222-22-2222			7 Name of employer District ABC			8 Employer identification number (EIN) 37-0000001									
3 Street address (including apartment no.) 123 Red Arrow Dr.						9 Street address (including room or suite no.) 52 Pike Dr.			10 Contact telephone number 555-555-5555									
4 City or town Berlin		5 State or province VT		6 Country and ZIP or foreign postal code 05602		11 City or town Berlin		12 State or province VT		13 Country and ZIP or foreign postal code 05602								
<b>Part II Employee Offer of Coverage</b>						<b>Plan Start Month (enter 2-digit number):</b> 01												
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
14 Offer of Coverage (enter required code) 1E																		
15 Employee Required Contribution (see instructions) \$ 50.00																		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C																		
<b>Part III Covered Individuals</b>																		
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																		
(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	June	July	Aug	Sept	Oct	Nov	Dec
17	Suzy	B	Smith	222-22-2222		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Truman	K	Smith	060-00-0066		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Cathy	C	Smith	003-00-0300		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Reporting Explanation

Suzy's situation remained the same, an offer of coverage, the contribution rate, and enrolled status for the entire 12 months, so we simply need to complete the 'All 12 months' boxes on the far left.

Line 14 - **1E** to indicate that Suzy was offered coverage for herself, her spouse and her dependents.

Line 15 - enter \$50, which is the employee contribution for employee-only coverage for the lowest cost plan for which Suzy is eligible.

Line 16 - **2C** to indicate that Suzy accepted coverage and was enrolled for the entire 12 months.

Part III reflects coverage for Suzy and her family for the entire year.



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 2 - Part time & participating all year

#### Key Points in the Scenario

- Lisa Jones is a **part-time** (fewer than 30 hours) employee working for School District ABC, a large district participating in VEHI
- School District ABC offers coverage to part time employees, their spouses and dependents
- Suzy, her spouse and dependents participate in family coverage for the entire year.
- Because Suzy was enrolled in coverage, a Form 1095-C is required to report the coverage information only.

#### Completing the 1095-C

Draft July 24, 2018		<b>1095-C</b>		<b>Employer-Provided Health Insurance Offer and Coverage</b>		<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED		600118 OMB No. 1545-2251 <b>2018</b>										
Form 1095-C Department of the Treasury Internal Revenue Service				Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.														
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>														
1 Name of employee (first name, middle initial, last name)		2 Social security number (SSN)		7 Name of employer		8 Employer identification number (EIN)												
Lisa B Jones		020-00-0020		District ABC		37-0000001												
3 Street address (including apartment no.)				9 Street address (including room or suite no.)		10 Contact telephone number												
PO Box 1043				52 Pike Dr.		555-555-5555												
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province										
East Corinth		VT		05040		Berlin		VT										
13 Country and ZIP or foreign postal code				14 Plan start month (enter 2-digit number):														
05602				01														
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month (enter 2-digit number):</b>														
All 12 Months				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec														
14 Offer of Coverage (enter required code)				1G														
15 Employee Required Contribution (see instructions)				\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$														
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																		
<b>Part III Covered Individuals</b>																		
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																		
(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	June	July	Aug	Sept	Oct	Nov	Dec
17	Lisa	B	Jones	020-00-0020		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Michael	K	Jones	010-00-0100		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Ed	C	Jones	003-00-0300		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Tara	A	Jones	004-04-0004		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Reporting Explanation

Because Lisa worked fewer than an average of 30 hours of service per week, the District need only report coverage information for Lisa and her family. The District enters **1G** on Line 14 in the 'All 12 months' boxes on the far left.

Under Part III, Lisa and all of her enrolled family members are listed with coverage, which was for all 12 months.



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 3 - Participating after a measurement period

#### Key Points in the Scenario

- Suzy Smith is hired by School District ABC on 5/1/17 and is considered to be a variable hour employee
- Suzy's **Initial** measurement period begins on 5/1/17 and continues through 4/30/18, at which time she's determined to have qualified for benefits as a full time employee
- Benefits are offered to Suzy during the administrative period with an effective date of 6/1/18
- Suzy elects coverage for herself, her spouse and her dependents
- The employee contribution for employee-only coverage in the lowest cost plan available to Suzy is \$50.00 per month, and coverage is affordable based on "rate of pay" safe harbor.

#### Completing the 1095-C

Draft July 24, 2018		Form <b>1095-C</b>		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 <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.		VOID		CORRECTED		OMB No. 1545-2251		2018		
<b>Part I Employee</b>						<b>Applicable Large Employer Member (Employer)</b>														
1 Name of employee (first name, middle initial, last name) Suzy B Smith			2 Social security number (SSN) 222-22-2222			7 Name of employer District ABC			8 Employer identification number (EIN) 37-0000001			9 Street address (including room or suite no.) 52 Pike Dr.			10 Contact telephone number 555-555-5555					
3 Street address (including apartment no.) 123 Red Arrow Dr.			4 City or town Berlin			5 State or province VT			6 Country and ZIP or foreign postal code 05602			11 City or town Berlin			12 State or province VT			13 Country and ZIP or foreign postal code 05602		
<b>Part II Employee Offer of Coverage</b>						<b>Plan Start Month (enter 2-digit number):</b> 01														
14 Offer of Coverage (enter required code)						All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec														
15 Employee Required Contribution (see instructions)						\$ 1H 1H 1H 1H 1H 1E 1E 1E 1E 1E 1E 1E														
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)						2D 2D 2D 2D 2D 2C 2C 2C 2C 2C 2C 2C														
<b>Part III Covered Individuals</b>																				
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																				
(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 June July Aug Sept Oct Nov Dec										
17 Suzy B Smith 222-22-2222										X X X X X X X X X X X X										
18 Truman K Smith 060-00-0066										X X X X X X X X X X X X										
19 Cathy C Smith 003-00-0300										X X X X X X X X X X X X										

#### Reporting Explanation

Suzy's situation changed mid year, so we need to take the codes month by month in each line.

Line 14, enter **1H** for January through May to indicate that Suzy was not offered coverage.

Line 15, leave January through May blank, and enter \$50 from June through December, which is the employee contribution for employee-only coverage for lowest cost plan for which Suzy is eligible.

Line 16, enter **2D** for January through May to indicate that Suzy was included in a measurement period as a variable hour employee (Limited Non-Assessment Period), then enter **2C** from June through December to indicate that Suzy accepted coverage and was enrolled for that time.

Part III, enter coverage information for all family members for each month an individual had at least one day of coverage.



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 4 - Mid month hire, participating in the plan

#### Key Points in the Scenario

- Suzy Smith is hired by School District ABC on 8/15/18 and is considered to be a full time employee
- At School District ABC, employees can join the plan the first day of the first month following their date of hire
- Suzy elects coverage for herself only
- Coverage is effective 9/1/18
- The monthly employee contribution for employee-only coverage in the lowest cost plan available to Suzy is \$50.00 per month, and coverage is affordable based on "rate of pay" safe harbor.

#### Completing the 1095-C

Draft July 24, 2018		Form <b>1095-C</b>		Employer-Provided Health Insurance Offer and Coverage		VOID		600118	
Department of the Treasury Internal Revenue Service		OMB No. 1545-2251		2018		CORRECTED			
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>					
1 Name of employee (first name, middle initial, last name)		2 Social security number (SSN)		7 Name of employer		8 Employer identification number (EIN)			
Suzy B Smith		222-22-2222		District ABC		37-0000001			
3 Street address (including apartment no.)				9 Street address (including room or suite no.)		10 Contact telephone number			
123 Red Arrow Dr.				52 Pike Dr.		555-555-5555			
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province	
Berlin		VT		05602		Berlin		VT	
13 Country and ZIP or foreign postal code				14 Plan Start Month (enter 2-digit number):					
05602				01					
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month (enter 2-digit number):</b>					
All 12 Months				Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec					
14 Offer of Coverage (enter required code)				1H 1H 1H 1H 1H 1H 1H 1H 1E 1E 1E 1E					
15 Employee Required Contribution (see instructions)				\$ \$ \$ \$ \$ \$ \$ \$ \$ 50.00 \$ 50.00 \$ 50.00 \$ 50.00					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)				2A 2A 2A 2A 2A 2A 2A 2D 2C 2C 2C 2C					
<b>Part III Covered Individuals</b>									
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>									
(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 months		(e) Months of Coverage	
First name, middle initial, last name								Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec	
17 Suzy B Smith		222-22-2222				<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	

#### Reporting Explanation

Suzy was hired mid-month and coverage was offered the first day of the first month following her hire, so we need to utilize codes that apply on a month by month basis.

Line 14, enter **1H** for January through August to indicate that no coverage was offered and enter **1E** from September to December to indicate that Suzy was offered coverage for herself, her spouse and her dependents.

Line 15, from September through December (months that coverage was offered), enter \$50 to indicate the employee contribution for employee-only coverage for the lowest cost plan for which Suzy is eligible.

Line 16, enter **2A** for January through July to indicate that Suzy was not employed, enter **2D** for August to indicate that Suzy was in a waiting period (Limited Non-Assessment Period), and enter **2C** for September through December to indicate that Suzy was enrolled during those months.

Part III reflects Suzy's coverage for the months of September through December.



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 5 - Employee waives coverage

#### Key Points in the Scenario

- Suzy Smith is a full time employee with School District ABC and is eligible for benefits
- School District ABC offers Minimum Essential Coverage to Suzy, including coverage for her family members
- The employee contribution for employee-only coverage in the lowest cost plan available to Suzy is \$50.00 per month, and coverage is affordable based on “rate of pay” safe harbor.
- Suzy *waives* coverage from School District ABC

#### Completing the 1095-C

Draft July 24, 2018 <b>Form 1095-C</b> Department of the Treasury Internal Revenue Service		<b>Employer-Provided Health Insurance Offer and Coverage</b> Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.				<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED		OMB No. 1545-2251 <b>2018</b>											
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>															
1 Name of employee (first name, middle initial, last name) Suzy B Smith		2 Social security number (SSN) 222-22-2222		7 Name of employer District ABC			8 Employer identification number (EIN) 37-0000001												
3 Street address (including apartment no.) 123 Red Arrow Dr.				9 Street address (including room or suite no.) 52 Pike Dr.			10 Contact telephone number 555-555-5555												
4 City or town Berlin		5 State or province VT		6 Country and ZIP or foreign postal code 05602		11 City or town Berlin		12 State or province VT											
				13 Country and ZIP or foreign postal code 05602															
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month (enter 2-digit number):</b> 01															
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code) 1E																			
15 Employee Required Contribution (see instructions) \$ 50.00		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2H																			
<b>Part III Covered Individuals</b>																			
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input type="checkbox"/>																			
(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	June	July	Aug	Sept	Oct	Nov	Dec
17						<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Reporting Explanation

Suzy's situation remained the same as it relates to the offer, contribution rate, and election to waive coverage for the entire 12 months, so we use the far left box in each line, the 'All 12 Months' box.

Line 14, enter **1E** to indicate that Suzy was offered coverage for herself, her spouse and her dependents.

Line 15, enter \$50 to indicate the employee contribution for employee-only coverage for the lowest cost plan for which Suzy is eligible.

Line 16, enter **2H** to indicate that Suzy waived coverage, and indicate that the coverage was determined affordable for Suzy under safe harbor provisions when using the “Rate of Pay” method.

Part III is not completed because Suzy was not enrolled in coverage for even one day during 2018.



## Example 6 - Employee waives UNAFFORDABLE coverage

### **Key Points in the Scenario**

- Suzy Smith is hired as a full time employee with School District XYZ 2/12/2018 and is eligible for benefits 3/1/2018
- School District XYZ offers Minimum Essential Coverage to Suzy, including coverage for her family members
- The employee contribution for employee-only coverage in the lowest cost plan available to Suzy is \$125.00 per month
- Using the Rate of Pay safe harbor, School District XYZ's coverage is **unaffordable**
- Suzy waives coverage from School District XYZ.

## Completing the 1095-C

[illegible]

### Reporting Explanation

Suzy's situation was not the same for the entire 12 months as it relates to the offer, contribution rate, and election to waive coverage, so we use the individual month boxes in each line.

Line 14, enter **1H** for January and February indicating Suzy was not offered coverage. For March through December we enter **1E** showing Suzy was offered coverage for herself, her spouse and her dependents during those months.

Line 15, enter \$125 to indicate the employee contribution for employee-only coverage for the lowest cost plan for which Suzy is eligible during the months Suzy was offered coverage.

Line 16, enter **2A** in January (not employed) and **2D** (waiting period) showing Suzy's status during those months. Since *Suzy's* coverage was **not affordable** and she did not enroll, **no code applies** so nothing is entered for March through December.

Part III is not completed because Suzy was not enrolled in coverage for even one day during 2018.







# IRS Reporting Resource Guide

## *COBRA Reporting Instructions and Examples*



### COBRA Reporting

#### **Termination of Employment**

Self-insured employers must report offers of COBRA coverage. Employers complete Form 1095-C providing COBRA coverage information (enrollment in COBRA coverage). How the Form 1095-C is completed will depend, in part, on whether the employee was covered as an active employee during 2018.

Former employees whose coverage terminated before 2018 and other COBRA-eligible family members electing COBRA will still receive a Form 1095-C providing proof of coverage for the former employee and other covered dependents, as applicable.

#### **Full-Time Status Change to Part-Time Status (not benefit eligible)**

In the limited cases where a full-time employee changes status from full-time / eligible for health plan benefits to a part-time position **not** eligible for health plan benefits, employers will complete Form 1095-C to show COBRA coverage was offered.

For the months the employee was full-time, employers complete Form 1095-C as appropriate for the particular employee. The difference is how an offer of COBRA coverage is reported.





# IRS Reporting Resource Guide

## COBRA Reporting Instructions and Examples



### Example 9 - COBRA Reporting, Continuing Employment

#### Key Points in the Scenario

- Suzy Smith began started working for School District ABC as a full-time employee at the end of 2016
- School District ABC offers full-time employees medical coverage, and the employees' spouses and dependents are eligible for the plan
- For the 2018 plan year **Suzy elected coverage for herself, her spouse and her dependents**
- The lowest cost plan for employee-only coverage is \$50.00 per month and coverage is affordable for Suzy based on "rate of pay" safe harbor
- Suzy changes from full-time status to part-time status (not eligible for District subsidized health plan coverage) effective October 1, 2018. Coverage for Suzy and her family ends on September 30
- Suzy elected family COBRA coverage effective October 1**

#### Completing the 1095-C

Draft July 24, 2018		Form <b>1095-C</b>		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 <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.		<input type="checkbox"/> VOID		OMB No. 1545-2251		600118											
												<input type="checkbox"/> CORRECTED		2018													
<b>Part I Employee</b>						<b>Applicable Large Employer Member (Employer)</b>																					
1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)			7 Name of employer			8 Employer identification number (EIN)																		
Suzy B Smith			222-22-2222			District ABC			37-0000001																		
3 Street address (including apartment no.)						9 Street address (including room or suite no.)						10 Contact telephone number															
123 Red Arrow Dr.						52 Pike Dr.						555-555-5555															
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code																	
Berlin		VT		05602		Berlin		VT		05602																	
<b>Part II Employee Offer of Coverage</b>						<b>Plan Start Month</b> (enter 2-digit number): 01																					
14 Offer of Coverage (enter required code)		All 12 Months		Jan		Feb		Mar		Apr		May		June		July		Aug		Sept		Oct		Nov		Dec	
1E																											
15 Employee Required Contribution (see instructions)		\$		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 567.09		\$ 567.09		\$ 567.09	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C																									
<b>Part III Covered Individuals</b>																											
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																											
(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 months		(e) Months of Coverage																	
First name, middle initial, last name										Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec																	
17 Suzy B Smith				222-22-2222				<input checked="" type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
18 Thad X Smith				333-33-0003				<input checked="" type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
19 Alicia K Smith				366-88-9955				<input checked="" type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	

#### Reporting Explanation

Line 14, enter **1E** in the boxes from January through September to indicate that Suzy was offered coverage for herself, her spouse and her dependents. Because Suzy had enrolled her spouse and dependent children for health plan coverage, the **family** was offered COBRA coverage. So, **1E** is also entered in October through December.

Line 15, enter \$50 to indicate the employee contribution toward the lowest cost employee-only coverage for the January through September boxes. For the October through December boxes we enter the employee-only cost of COBRA coverage for the lowest cost plan available to Suzy, in this case \$567.90

Line 16, enter **2C** in the boxes from January through September to indicate that Suzy was enrolled in coverage for those months. Because Suzy enrolled for COBRA coverage we enter **2C** in the boxes for October through December.

Part III must reflect both active and COBRA coverage so we can check the 'All 12 Months' box for each family member. If no one elected COBRA, the only change in the form would be Part III showing the months of coverage.



# IRS Reporting Resource Guide

## COBRA Reporting Instructions and Examples



### Example 10 - COBRA Reporting, Continuing Employment

#### Key Points in the Scenario

- Suzy Smith began started working for School District ABC as a full-time employee at the end of 2016
- School District ABC offers full-time employees medical coverage, and the employees' spouses and dependents are eligible for the plan
- For the 2018 plan year **Suzy elected coverage for herself, her spouse and her dependents**
- The lowest cost plan for employee-only coverage is \$50.00 per month and coverage is affordable for Suzy based on "rate of pay" safe harbor
- Suzy changes from full-time status to part-time status (not eligible for District subsidized health plan coverage) effective October 1, 2018. Coverage for Suzy and her family ends on September 30
- Suzy elected employee-only COBRA coverage effective October 1**

#### Completing the 1095-C

<b>Draft July 24, 2018</b> <b>Form 1095-C</b> Department of the Treasury Internal Revenue Service		<b>Employer-Provided Health Insurance Offer and Coverage</b> Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.		<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED	OMB No. 1545-2251 <b>2018</b>																																																								
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>																																																									
1 Name of employee (first name, middle initial, last name) <b>Suzy B Smith</b>		2 Social security number (SSN) <b>222-22-2222</b>		7 Name of employer <b>District ABC</b>																																																									
3 Street address (including apartment no.) <b>123 Red Arrow Dr.</b>		9 Street address (including room or suite no.) <b>52 Pike Dr.</b>		8 Employer identification number (EIN) <b>37-0000001</b>																																																									
4 City or town <b>Berlin</b>		5 State or province <b>VT</b>		10 Contact telephone number <b>555-555-5555</b>																																																									
6 Country and ZIP or foreign postal code <b>05602</b>		11 City or town <b>Berlin</b>		12 State or province <b>VT</b>																																																									
13 Country and ZIP or foreign postal code <b>05602</b>		14 Plan Start Month (enter 2-digit number): <b>01</b>																																																											
<b>Part II Employee Offer of Coverage</b>																																																													
<table border="1"> <tr> <th></th> <th>All 12 Months</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>June</th> <th>July</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> </tr> <tr> <td>14 Offer of Coverage (enter required code) <b>1E</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>15 Employee Required Contribution (see instructions) \$</td> <td></td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 50.00</td> <td>\$ 567.09</td> <td>\$ 567.09</td> <td>\$ 567.09</td> </tr> <tr> <td>16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>							All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	14 Offer of Coverage (enter required code) <b>1E</b>														15 Employee Required Contribution (see instructions) \$		\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 567.09	\$ 567.09	\$ 567.09	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec																																																
14 Offer of Coverage (enter required code) <b>1E</b>																																																													
15 Employee Required Contribution (see instructions) \$		\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 567.09	\$ 567.09	\$ 567.09																																																
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>																																																													
<b>Part III Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																																																													
(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	June	July	Aug	Sept	Oct	Nov	Dec																																													
17	<b>Suzy B Smith</b>	<b>222-22-2222</b>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																													
18	<b>Thad X Smith</b>	<b>333-33-0003</b>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																													
19	<b>Alicia K Smith</b>	<b>366-88-9955</b>		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																													

#### Reporting Explanation

Line 14, enter **1E** in the boxes from January through September to indicate that Suzy was offered coverage for herself, her spouse and her dependents. Because Suzy had enrolled her spouse and dependent children for health plan coverage, the **family** was offered COBRA coverage. So, **1E** is also entered in October through December.

Line 15, enter \$50 to indicate the employee contribution toward the lowest cost employee-only coverage for the January through September boxes. For the October through December boxes we enter the employee-only cost of COBRA coverage for the lowest cost plan available to Suzy, in this case \$567.90

Line 16, enter **2C** in the boxes from January through September to indicate that Suzy was enrolled in coverage for those months. Because Suzy enrolled for COBRA coverage we enter **2C** in the boxes for October through December.

Part III must reflect both active and COBRA coverage we check the 'All 12 Months' box for Suzy and January through September for the other family members.



# IRS Reporting Resource Guide

## COBRA Reporting Instructions and Examples



### Example 11 - COBRA Reporting, Continuing Employment

#### Key Points in the Scenario

- Suzy Smith began started working for School District ABC as a full-time employee at the end of 2016
- School District ABC offers full-time employees medical coverage, and the employees' spouses and dependents are eligible for the plan
- For the 2018 plan year **Suzy elected employee only coverage**
- The lowest cost plan for employee-only coverage is \$50.00 per month and coverage is affordable for Suzy based on "rate of pay" safe harbor
- Suzy changes from full-time status to part-time status (not eligible for District subsidized health plan coverage) effective October 1, 2018. Coverage for Suzy ends on September 30
- Suzy does not elect COBRA coverage for herself**

#### Completing the 1095-C

Draft July 24, 2018		<b>1095-C</b>		Employer-Provided Health Insurance Offer and Coverage		<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED		OMB No. 1545-2251		2018																					
Form 1095-C Department of the Treasury Internal Revenue Service		Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.																													
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>																											
1 Name of employee (first name, middle initial, last name) Suzy B Smith		2 Social security number (SSN) 222-22-2222		7 Name of employer District ABC		8 Employer identification number (EIN) 37-0000001																									
3 Street address (including apartment no.) 123 Red Arrow Dr.				9 Street address (including room or suite no.) 52 Pike Dr.		10 Contact telephone number 555-555-5555																									
4 City or town Berlin		5 State or province VT		6 Country and ZIP or foreign postal code 05602		11 City or town Berlin		12 State or province VT		13 Country and ZIP or foreign postal code 05602																					
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month (enter 2-digit number): 01</b>																											
All 12 Months		Jan		Feb		Mar		Apr		May		June		July		Aug		Sept		Oct		Nov		Dec							
14 Offer of Coverage (enter required code)		1E		1E		1E		1E		1E		1E		1E		1E		1E		1B		1B		1B							
15 Employee Required Contribution (see instructions)		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 50.00		\$ 567.09		\$ 567.09		\$ 567.09							
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C		2C		2C		2C		2C		2C		2C		2C		2C		2H		2H		2H							
<b>Part III Covered Individuals</b>																															
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																															
(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		June		July		Aug		Sept		Oct		Nov		Dec	
17 Suzy B Smith		222-22-2222				<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			

#### Reporting Explanation

There is a real difference in the coding on the form.

Line 14, enter **1E** in the boxes from January through September to tell the IRS that Suzy was offered coverage for herself, her spouse and her dependents. However, since only Suzy enrolled for active coverage, only Suzy is offered COBRA. When only Suzy is offered COBRA the Line 14 code is **1B** for October through December. 1B means 'Minimum essential coverage providing minimum value offered to employee only'. Since this is COBRA coverage it will not result in a penalty to the District, but that is how the IRS is looking for the information.

Line 15, enter \$50 to indicate the employee contribution toward the lowest cost employee-only coverage for the January through September boxes. However, for the October through December boxes we enter the employee-only cost of COBRA coverage for the lowest cost plan available to Suzy, in this case \$567.90

Line 16, enter **2C** in the boxes from January through September to indicate that Suzy was enrolled in coverage for those months. Because Suzy did not enroll for COBRA coverage we enter **2H** (rate of pay affordability, the method applicable based on Suzy's coverage while active) for October through December.

Part III reflects Suzy's coverage only while a full-time employee.





### ***Please Note The Following***

- All SDs or SUs that were in operation at any time in 2018 with at least 50 FT/FTEs need to report for all of 2018
- Where SDs or SUs with fewer than 50 FT/FTE merged **and** where the merged entity had at least 50 FT/FTEs on July 1, the new or continuing entity must begin filing July 1 for the balance of 2018
- Where the operations of any SD/SU ended during 2018, the Form 1095-C is completed for each FT employee for January through June, completing the codes as applicable
- Beginning July 1 the Form 1095-C will show all employees terminated using:
  - Line 14 – Code 1H
  - Line 15 – Blank
  - Line 16 – 2A
- For the examples we will assume that SDs or SUs:
  - offers full-time employees medical coverage, and the employees' spouses and dependents are eligible for the plan
  - the lowest cost plan for employee-only coverage is \$50.00 per month and the coverage has been determined to be affordable based on "rate of pay" safe harbor



# IRS Reporting Resource Guide

## Merging Districts



### Example 12 – Merging Districts

#### Key Points in the Scenario

- On January 1, Suzy is a full-time employee of District XYZ and has been enrolled in coverage for over a year
- Suzy is enrolled in coverage for herself.
- On July 1 Suzy becomes an employee of District ABC as part of the merging of the Districts
- Suzy continues employee-only coverage and remains employed as a full-time employee for all of 2018

### DISTRICT XYZ FORM 1095-C

#### Completing the 1095-C

Draft July 24, 2018		<b>1095-C</b>		Employer-Provided Health Insurance Offer and Coverage		<input type="checkbox"/> VOID		OMB No. 1545-2251		600118									
Form 1095-C Department of the Treasury Internal Revenue Service		Do not attach to your tax return. Keep for your records.		Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.		<input type="checkbox"/> CORRECTED		2018											
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>															
1 Name of employee (first name, middle initial, last name) Suzy B Smith		2 Social security number (SSN) 222-22-2222		7 Name of employer District XYZ				8 Employer identification number (EIN) 32-0000002											
3 Street address (including apartment no.) 123 Red Arrow Dr.				9 Street address (including room or suite no.) 1267 Grant View Drive				10 Contact telephone number 555-555-5555											
4 City or town Berlin		5 State or province VT		6 Country and ZIP or foreign postal code 05602		11 City or town Warren		12 State or province VT		13 Country and ZIP or foreign postal code 05674									
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month (enter 2-digit number):</b> 07															
		All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code)			1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	1H					
15 Employee Required Contribution (see instructions)		\$	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$	\$	\$	\$	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2A	2A	2A	2A	2A	2A					
<b>Part III Covered Individuals</b>																			
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																			
(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	June	July	Aug	Sept	Oct	Nov	Dec
17 Suzy B Smith		222-22-2222				<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Reporting Explanation

- District XYZ ceased operations midyear:
  - Line 14, enter **1E** in the boxes from January through June to indicate that Suzy was offered coverage for herself, her spouse and her dependents. **Beginning July 1** the code changes to **1H**, no offer of coverage
  - Line 15, enter \$50 to indicate the employee contribution toward the lowest cost employee-only coverage for the January through June
  - Line 16, enter **2C** in the boxes from January through June to indicate that Suzy was enrolled in coverage for those months. **Beginning in July** the code changes to **2A** – Not employed.
  - Part III reflects Suzy's coverage only while a full-time employee.



# IRS Reporting Resource Guide

## Merging Districts



### Example 12 – Merging Districts, cont.

#### DISTRICT ABC FORM 1095-C

#### Completing the 1095-C

Draft July 24, 2018 <b>1095-C</b> Form Department of the Treasury Internal Revenue Service		<b>Employer-Provided Health Insurance Offer and Coverage</b> Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.		<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED		OMB No. 1545-2251 <b>2018</b>													
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>															
1 Name of employee (first name, middle initial, last name) Suzy B Smith		2 Social security number (SSN) 222-22-2222		7 Name of employer District ABC		8 Employer identification number (EIN) 37-0000001													
3 Street address (including apartment no.) 123 Red Arrow Dr.				9 Street address (including room or suite no.) 52 Pike Drive		10 Contact telephone number 555-555-5555													
4 City or town Berlin		5 State or province VT		6 Country and ZIP or foreign postal code 05602		11 City or town Berlin													
				12 State or province VT		13 Country and ZIP or foreign postal code 05602													
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month</b> (enter 2-digit number): 07															
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec						
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E						
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00						
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2C	2C	2C	2C	2C	2C						
<b>Part III Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input checked="" type="checkbox"/>																			
(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	June	July	Aug	Sept	Oct	Nov	Dec
17 Suzy B Smith		222-22-2222				<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

#### Reporting Explanation

- Because Suzy is now employed by District ABC, that District codes Suzy as a new employee, but no waiting period
- Line 14, code **1H** for January through June – No offer of coverage and we enter **1E** in July through December to indicate that Suzy was offered coverage for herself, her spouse and her dependents
- Line 15, enter \$50 to indicate the employee contribution toward the lowest cost employee-only coverage for the July through December
- Line 16, enter **2A** in the boxes from January through June to indicate that Suzy was not employed for those months. For July through December we enter **2C** in the boxes to indicate that Suzy was enrolled in coverage for those months
- Part III reflects Suzy's coverage only while a full-time employee.



# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 13 – Completing Form 1094-C

Form 1094-C is used as a transmittal form for the Forms 1095-C filed with the IRS. However, the purpose goes beyond just a transmittal form. The information requested on this form is used by the IRS to determine if an employer has met the employer shared responsibility mandate (requirement to offer 95% of all full-time employees qualifying coverage). By signing this form, the signer attests to the accuracy of the information submitted. **Note:** Part IV of the Form 1094-C is not completed.

**Draft July 11, 2018**

Form **1094-C** **Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns** ☐ CORRECTED **OMB No. 1545-2251**

Department of the Treasury  
Internal Revenue Service **2018**

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

1 Name of ALE Member (Employer)  
**District ABC**

2 Employer identification number (EIN)  
**37-0000001**

3 Street address (including room or suite no.)  
**52 Pike Dr.**

4 City or town  
**Berlin**

5 State or province  
**VT**

6 Country and ZIP or foreign postal code  
**05602**

7 Name of person to contact  
**John Adams**

8 Contact telephone number  
**555-555-5555**

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

17 Reserved

18 Total number of Forms 1095-C submitted with this transmittal **347**

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

**Part II ALE Member Information**

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member **347**

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. Reserved ☐ C. Reserved ☐ 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 \_\_\_\_\_

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2018)

**Part I – Applicable Large Employer Member (employer) information.** The employer and address should match the information entered on the Form 1095-Cs relating to the employer.

The contact name and telephone number should be to a person with the employer who can respond to questions about the Form 1094-C and the accompanying Form 1095-Cs.

Line 18, enter the total number of Form 1095-C being submitted with the Form 1094-C (generally all forms).

Line 19, check the box if the Form 1094-C is the authoritative Form 1094-C. Unless you are submitting more than one filing, this box should be checked.



# IRS Reporting Resource Guide

## *Examples for VEHI Members*



### Example 13 – Completing Form 1094-C, cont.

#### **Lines 18 - 19**

In most cases employers will submit all Form 1095-Cs with a single Form 1094-C. If this is the case, Line 18 and Lines 20 should match and Line 19 should be marked indicating the Form 1094-C is the 'authoritative transmittal'. Only one authoritative transmittal should be submitted.

#### **Part II – ALE Member Information (employer)**

##### **Line 20**

Enter the total number of Form 1095-C being submitted with all 1094-C transmittal forms submitted by the employer.

##### **Line 21**

Check this box no.

##### **Line 22**

If the employer is using the 'Qualifying Offer Method' or the '98% Offer Method' when submitting Forms 1095-C, the applicable box must be checked.





# IRS Reporting Resource Guide

## Examples for VEHI Members



### Example 13 – Completing Form 1094-C, cont.

#### Part III

This section collects information about the employer's offer of minimum essential coverage (MEC) to full-time employees.

**Column (a)** – here the employer is asked to indicate during which months the employer offered MEC to at least 95% of all full-time employees. The employer's back-up data and the Forms 1095-C should support a claim of offering 95% of full-time employees coverage for each of the months. If the employer offered coverage to 95% of all full-time employees for all 12 months, the employer checks 'yes' under column (a) on line 23, otherwise the employer checks the applicable box for each of the calendar months.

**Column (b)** - Employers enter the number of full-time employees for each calendar month of the year.

**Column (c)** – Employers enter the total number of employees for each of the calendar months of the year.

For more detail on completing these counts, see the 'IRS Reporting Guide for Large School Districts and Supervisory Unions' located on the VEHI website.

Draft July 11, 2018						120218
Form 1094-C (2018)						Page 2
Part III ALE Member Information – Monthly						
	(a) Minimum Essential Coverage Offer Indicator		(b) Section 4980H Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Reserved
	Yes	No				
23 All 12 Months	<input checked="" type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24 Jan	<input type="checkbox"/>	<input type="checkbox"/>	299	315	<input type="checkbox"/>	
25 Feb	<input type="checkbox"/>	<input type="checkbox"/>	299	315	<input type="checkbox"/>	
26 Mar	<input type="checkbox"/>	<input type="checkbox"/>	297	314	<input type="checkbox"/>	
27 Apr	<input type="checkbox"/>	<input type="checkbox"/>	302	319	<input type="checkbox"/>	
28 May	<input type="checkbox"/>	<input type="checkbox"/>	302	319	<input type="checkbox"/>	
29 June	<input type="checkbox"/>	<input type="checkbox"/>	277	289	<input type="checkbox"/>	
30 July	<input type="checkbox"/>	<input type="checkbox"/>	276	289	<input type="checkbox"/>	
31 Aug	<input type="checkbox"/>	<input type="checkbox"/>	283	291	<input type="checkbox"/>	
32 Sept	<input type="checkbox"/>	<input type="checkbox"/>	301	317	<input type="checkbox"/>	
33 Oct	<input type="checkbox"/>	<input type="checkbox"/>	301	317	<input type="checkbox"/>	
34 Nov	<input type="checkbox"/>	<input type="checkbox"/>	303	318	<input type="checkbox"/>	
35 Dec	<input type="checkbox"/>	<input type="checkbox"/>	302	318	<input type="checkbox"/>	

Form 1094-C (2018)