Form **1095-C**
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 *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251 600120

2023

Part I Employee

1 Name of employee (first name, middle initial, last name)		2 Social security number (SSN)
VAIBHAVI	M PATEL	XXX-XX-5594
3 Street address (including apartment no.)		
128 MAIN ST APT 2B		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
BINGHAMTON	NY	US 13905

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
STATE OF NEW YORK	14-6013200
9 Street address (including room or suite no.)	10 Contact telephone number
110 STATE STREET	8443376297
11 City or town	12 State or province	13 Country and ZIP or foreign postal code
ALBANY	NY	US 12236

Part II Employee Offer of Coverage

Employee's Age on January 1:

Plan Start Month (enter 2-digit number): 01

	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)	$	$	$	$	$	$	$	$ 104.92	$ 104.92	$ 104.92	$ 104.92	$ 104.92	$ 104.92
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2F	2F	2F	2F	2F	2B
17 ZIP Code													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(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
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