

# Employer-Provided Health Insurance Offer and Coverage

VOID  
 CORRECTED

OMB No. 1545-2281 **600117**  
**2017**

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

Employer identification number (EIN)  
05-0340626

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

2 Social security number (SSN)  
\*\*\*-\*\*-8199

Applicable Large Employer Member (Employer)

**Part I Employee**

1 Name of employee  
MOBY GEORGE

7 Name of employer  
CVS PHARMACY, INC.

3 Street address (including apartment no.)  
2385 DIAMOND HILL ROAD APT# 8

9 Street address (including room or suite no.)  
1 CVS DRIVE

4 City or town  
WOONSOCKET

5 State or province  
RI

6 Country and ZIP or foreign postal code  
02895

11 City or town  
WOONSOCKET

12 State or province  
RI

10 Contact telephone number  
888-694-7287

13 Country and ZIP or foreign postal code  
02895

Plan Start Month (Enter 2-digit number): 06

**Part II Employee Offer of Coverage**

4 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
	5 Employee Required Contribution (see instructions)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
6 Section 4980H Safe Harbor and Other Relief (enter code, applicable)		\$ 113.24	\$ 113.24	\$ 113.24	\$ 113.24	\$ 113.24	\$ 120.83	\$ 120.83	\$ 120.83	\$ 120.83	\$ 120.83	\$ 120.83	\$ 120.83
		2C	2C	2C	2H		2H	2H	2H	2H	2H	2H	2H

**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)	(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 MOBY GEORGE	***-**-8199			X	X	X											
18 ANN ALEX	***-**-5547			X	X	X											
19 ROSERAH MOBY	***-**-9358			X	X	X											
20																	
21																	
22																	

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

Cat. No. 60705M

Form 1095-C (2017)

**600317**  
Page 3

Form 1095-C (2017)

Name of employee  
MOBY GEORGE

Social security number (SSN)  
\*\*\*-\*\*-8199

**Part III Covered Individuals - Continuation Sheet**

(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													
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
23																	
24																	
25																	
26																	
27																	
28																	
29																	
30																	
31																	
32																	
33																	
34																	

Form 1095-C (2017)