

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 **600117**
2017

Part I Employee		2 Social security number (SSN) ***-**-6560		Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 94-1687665	
1 Name of employee THANGADURAI MOTACI SEBASTIAN VALAN				7 Name of employer BANK OF AMERICA NATIONAL ASSOC			
3 Street address (including apartment no.) 2683 RED MAPLE LANE				9 Street address (including room or suite no.) 100 NORTH TRYON STREET SUITE 170			
4 City or town HARRISBURG		5 State or province NC		6 Country and ZIP or foreign postal code 28075		11 City or town CHARLOTTE	
						12 State or province NC	
				13 Country and ZIP or foreign postal code 28202			

Part II Employee Offer of Coverage		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)			1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$		\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43	\$ 137.43
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F

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. <input 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												
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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Part III Covered Individuals - Continuation Sheet		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)	(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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