Sample IRS Form 1095-B

Form **1095-B**
Department of the Treasury
Internal Revenue Service

Health Coverage

➤ Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b*.

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OMB No. 1545-2252

2015

Part I Responsible Individual (Policy Holder)

1 Name of responsible individual PersonOne Woman	2 Social security number (SSN)	3 Date of birth (if SSN is not available)

4 Street address (including apartment no.) 123 Main St	5 City or town Raleigh	6 State or province NC	7 Country and ZIP or foreign postal code US 27612

8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . ➤ C	9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable

Part II Employer Sponsored Coverage (If Line 8 is A or B, complete this part.)

10 Employer Name	11 Employer identification number (EIN)

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider

16 Name NC Dept. of Health & Human Services	17 Employer identification number (EIN) 561250855	18 Contact telephone number 1-888-245-0179

19 Street address (including room or suite no.) 2501 Mail Service Center	20 City or town Raleigh	21 State or province NC	22 Country and ZIP or foreign postal code 27699-2501

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

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 PersonOne Woman					X	X	X	X	X	X	X	X	X	X	X
2 PersonTwo Child					X	X	X	X	X	X	X	X	X	X	X
3															
4															
5															
6															

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form 1095-B (2015)

For more information, visit http://www.ncdhhs.gov/ and click the link for 1095B
DMA Call Center: 1-888-245-0179 or 919-855-4780

AIR1095B (Rev. 12/15)

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.*

TIP: *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Caution: *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

A. Small Business Health Options Program (SHOP)
B. Employer-sponsored coverage
C. Government-sponsored program
D. Individual market insurance
E. Multiemployer plan
F. Other designated minimum essential coverage

TIP: *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will be reported on a Form 1095-A rather than a Form 1095-B.*

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. If your coverage isn't insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

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