Reporting Tool Kit

Your Guide to 2023 Reporting

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FORM 1095 PRINT APPROVAL

Review and approve forms for printing with ease

CREATE NEW REVIEW

Submission Approval | Submission Review | Submitted Batches | Pending Batches | Batch Hold | Manual Forms

Print Approval

Create / Select Approval → 1095-C → 1095-B → Approval Summary

1 Please create a title for future reference
Tax Year: 2023
Type: Print Approval

2 Title:

3 Please select which forms to review
1095-B/C: Federal CA DC NJ RI

Please select which FEINs to review
Select All Select None

4 Form type FEINs
Sample Company-1 (100000001)

5 Review a total of 10 records across the selected FEINs

6 BEGIN NEW APPROVAL

1 Select Tax Year and Type

Tax Year: 2023
Type: Print Approval

2 Create An Appropriate Title

Title:

3 Select Forms To Review

Please select which forms to review
1095-B/C: Federal CA DC NJ RI

4 Select All FEINs

FEINs
Sample Company (581519913) Sample Company
Sample Company 3 (581651002) Sample Company

5 Choose # to Review

Review a total of 10 records across the selected FEINs

6 Begin Review

BEGIN NEW APPROVAL

REVIEW FORMS

Form 1095-C — Employer-Provided Health Insurance Offer and Coverage
Department of the Treasury, Internal Revenue Service
▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095C for instructions and the latest information.
CORRECTED — OMB No. 1545-2251 — 2023

Part I Employee
1 Name of employee (first name, middle initial, last name): User M.I. One
2 Social security number (SSN): XXXXX5555
3 Street address (including apartment no.): 123 Main Street
4 City or town: Example
5 State or province: MO
6 Country and ZIP or foreign postal code: US 12345

Applicable Large Employer Member (Employer)
7 Name of employer: Sample Company-1
9 Street address (including room or suite no.): 1 Main Street
11 City or town: Sample City
12 State or province: GA

Part II Employee Offer of Coverage — Unlock Months for Edit — Employee's Age on January 1: Age

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug
14 Offer of Coverage (enter required code)	1E								
15 Employee Required Contribution (see instructions)	$102.00								
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C								
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.

Remove		(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	Jan
	18	User	M.I.	One	XXXXX5555	DOB (Month/day/year) if SSN unknown	☐	☑
	19	User	M.I.	Two	XXXXX7777	DOB (Month/day/year) if SSN unknown	☐	☑
	20	First Name	M.I.	Last Name		DOB (Month/day/year) if SSN unknown	☐	☐
	21	First Name	M.I.	Last Name		DOB (Month/day/year) if SSN unknown	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M

Approved? Yes No (2) (3)
Comments:

◀ PREVIOUS EMPLOYEE — NEXT EMPLOYEE ▶ (4)

1 Verify Accuracy Of All Parts

Part I Employee
1 Name of employee
Part II Employee Offer and Coverage
All 12 Months

2 If All Is Accurate

Approved?
Yes No

3 If Errors Exist

Approved?
Yes No
Comments:
Insert comments explaining error

4 Continue Through All Forms

NEXT EMPLOYEE ▶

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REVIEW COMPLETED WITH ERRORS

1095-C	100000003	XXX-XX-0001	RI	Review Form	Sample Error Comment
1095-C	100000005	XXX-XX-0002	RI	Review Form	Sample Error Comment
1095-C	100000001	XXX-XX-0003	RI	Approved	
1095-C	100000001	XXX-XX-0004	RI	Approved	
1095-C	100000002	XXX-XX-0005	CA	Approved	
1095-C	100000002	XXX-XX-0006	CA	Approved	
1095-C	100000003	XXX-XX-0007	CA	Approved	
1095-C	100000003	XXX-XX-0008	CA	Approved	
1095-C	100000004	XXX-XX-0009	CA	Approved	
1095-C	100000004	XXX-XX-0010	CA	Approved	
1095-C	100000005	XXX-XX-0011	CA	Approved	
1095-C	100000001	XXX-XX-0012	CA	Approved	
1095-C	100000002	XXX-XX-0013	CA	Approved	
1095-C	100000004	XXX-XX-0014	CA	Approved	
1095-C	100000001	XXX-XX-0015	DC	Approved	

Incorrect Data
One or more data item(s) have been marked as incorrect.
Please review all items marked "Review Form" in the list above.

1 If Errors Exist

Incorrect Data
One or more data item(s) have been marked as incorrect.
Please review all items marked "No" in the list above.

2 Research and Fix

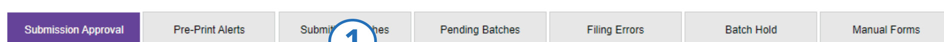
1095-C	100000003	XXX-XX-0001	RI	Review Form	Sample Error Comment
1095-C	100000005	XXX-XX-0002	RI	Review Form	Sample Error Comment
1095-C	100000001	XXX-XX-0003	RI	Approved	

3 Repeat New Review

BEGIN NEW APPROVAL

Changes can only be made via the Employee Details page. You will not be able to make changes in Print Approval. If a change has been made, it will not update the snapshot on the current print approval. A new review needs to be started and the employee specifically would need to be added to the new review.

REVIEW COMPLETED WITHOUT ERRORS

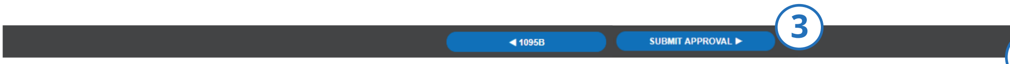


Print Approval

2022 Print Approval Summary

Form Type	FEIN	EE#	Recipient	Result	Comment
1095-C	100000001	XXX-XX-1102	Federal	Approved	
1095-C	100000001	XXX-XX-1115	Federal	Approved	
1095-C	100000002	XXX-XX-2105	Federal	Approved	
1095-C	100000002	XXX-XX-1608	Federal	Approved	
1095-C	100000003	XXX-XX-2101	Federal	Approved	
1095-C	100000003	XXX-XX-2115	Federal	Approved	

Actions
- [x] Submission for print/electronic delivery to employees
- [x] I declare that I have examined these forms and to the best of my knowledge and belief, they are true, correct and complete for all associated FEINs.



1 If No Errors Exist

2 Click Top/Bottom Action

Actions
- [x] Submission for print/electronic delive
- [x] I declare that I have examined these f

3 Submit and Print

SUBMIT APPROVAL ►

4 Notify Account Manager

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2023 FORM 1095-C AT A GLANCE

A quick reference guide to Form 1095-C

Form 1095-C identifies whether an employee was offered coverage and whether the employee was enrolled in coverage at any time during the tax year. This guide provides need-to-know details about how employers should complete and transmit Form 1095-C.

Form 1095-C: The Basics

Applicable Large Employer (ALE) Members are either: a person or entity that is an Applicable Large Employer, or each person or entity within an Aggregated ALE Group. ALE Members must file Form 1095-C for every full-time employee eligible for medical coverage. Forms 1095-C must be transmitted to the IRS with Form 1094-C. Together, these forms are used to determine whether an employer is subject to penalty under the employer shared responsibility provisions under Section 4980H.

How to complete Form 1095-C

Form 1095-C has three parts:

1. **Part I – Employee & ALE Information:** Provides specific information about the employee and the ALE.
2. **Part II – Offer of Coverage:** Identifies whether the employee was full-time for any month of the calendar year AND whether a plan was offered during any month of the calendar year. (See Additional Information for more details.)
3. **Part III – Covered Individuals:** Identifies individuals who had coverage for any month during the calendar year.

Employers must fill out the appropriate form sections based on the type of plans that are offered:

- Fully insured plans: complete only Parts I and II.
- Self-insured plans: complete Parts I, II, and III.
- Individual Coverage Health Reimbursement Arrangement (ICHRA) plans: complete Parts I, II, and III.

Additional Information About Form 1095-C:

4. **Employee's Age on January 1st:** Shows the employee's age on January 1st if they were offered an individual coverage Health Reimbursement Arrangement (HRA). The age in this field may not match the age used for the silver premium if the plan year does not start in January.
5. **Plan Start Month:** Identifies the first month of the plan year of the plan offered to the employee.
6. **Line 14 (Code Series 1):** Identifies the type of coverage offered to an employee. Line 14 cannot be left blank.
7. **Line 15:** Identifies the employee's share of the lowest-cost self-only minimum essential coverage plan that provides minimum value that's offered to the employee (this may not be the amount the employee pays for coverage). If an ICHRA plan is offered, the following formula determines the employee contribution: (age and location based on lowest cost silver plan monthly premium) – (monthly employer ICHRA contribution amount) = (employee contribution used to determine affordability of coverage under the ACA). Line 15 should only be used if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, or 1Q is entered on Line 14 or in the 'All 12 Months' checkbox.
8. **Line 16 (Code Series 2):** Identifies applicable Section 4980H affordability safe harbor or other relief for ALE Members. Line 16 may be left blank if no code applies.
9. **Line 17:** Identifies the ZIP code used to calculate the employee contribution for an individual coverage HRA offer on Line 15. The ZIP code is either for the employee's primary residence or for their primary employment site. ZIP code is only included when an ICHRA plan is offered.

Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095c.pdf)

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.

☐ CORRECTED — OMB No. 1545-2251 — 2023

Part I Employee | Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)	7 Name of employer	8 Employer identification number (EIN)
User M.I. One	XXXXX5555	Sample Company-1	100000001

3 Street address (including apartment no.)	9 Street address (including room or suite no.)	10 Contact telephone number
123 Main Street	1 Main Street	111-234-5678

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
Example	MO	US 12345	Sample City	GA	US 12345

Part II Employee Offer of Coverage — Unlock Months for Edit — Employee's Age on January 1: Age — 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												
15 Employee Required Contribution (see instructions)	$102.00												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
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
18	User M.I. One	XXXXX5555	DOB (Month/day/year) if SSN unknown	☐	☑	☑	☑	☑	☑	☑	☑	☐	☐	☐	☐	☐
19	User M.I. Two	XXXXX7777	DOB (Month/day/year) if SSN unknown	☐	☑	☑	☑	☑	☑	☑	☑	☐	☐	☐	☐	☐
20	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Line 14 Code Series 1

Code	Description
1A	Qualifying offer: Minimum essential coverage (MEC) providing minimum value (MV) offered to the full-time employee with the employee contribution for self-only coverage equal to or less than 9.83% of the mainland single federal poverty line and at least minimum essential coverage offered to the spouse and dependent(s). The employee must be offered for every day of the month for this code to be used.
1B	MEC providing MV offered to employee ONLY.
1C	MEC providing MV offered to the employee and at least MEC offered to the employee's dependent(s) but NOT to the spouse.
1D	MEC providing MV offered to the employee and at least MEC offered to the spouse but not to the dependent(s). If the offer of coverage to the spouse was conditional, use code 1J.
1E	MEC providing MV offered to the employee and at least MEC to the dependent(s) and spouse. If the offer of coverage to the spouse was conditional, use code 1K. The employee must be offered for every day of the month for this code to be used.
1F	MEC NOT providing MV offered to either: the employee; or to employee and spouse or dependent(s); or to employee, spouse, and dependents.
1G	Offer of coverage to employee who was not a full-time employee for any month of the calendar year or to an employee who was not a full-time employee for any month of the calendar year and who enrolled in self-insured coverage for one or more months of the calendar year.
1H	No offer of coverage (employee not offered any health coverage or employee offered coverage that is not MEC).
1I	Reserved.
1J	MEC providing MV offered to employee and at least MEC conditionally offered to spouse; MEC not offered to dependent(s).
1K	MEC providing MV offered to employee and at least MEC conditionally offered to dependents; and at least MEC conditionally offered to spouse.
1L	Individual coverage HRA only offered to the employee. Affordability is determined using the employee's primary residence ZIP code.
1M	Individual coverage HRA offered to the employee and dependent(s), but NOT to the spouse. Affordability is determined using the employee's primary residence ZIP code.
1N	Individual coverage HRA offered to the employee, spouse, and dependent(s). Affordability is determined using the employee's primary residence ZIP code.
1O	Individual coverage HRA only offered to employees using the employee's primary employment site ZIP code affordability safe harbor.
1P	Individual coverage HRA offered to employee and dependent(s), but NOT to the spouse, using the employee's primary employment site ZIP code affordability safe harbor.
1Q	Individual coverage HRA offered to employee, spouse, and dependent(s), using the employee's primary employment site ZIP code affordability safe harbor.
1R	Individual coverage HRA that is NOT affordable offered to either: the employee; the employee and spouse or dependent(s); employee, spouse, and dependent(s).
1S	Individual coverage HRA offered to an individual who was not a full-time employee.

Line 16 Code Series 2

Code	Description
2A	The employee was not employed on any day of the month. This code should not be used in the month an employee terminates employment with the ALE Member.
2B	The employee is not a full-time employee for the month and did not enroll in MEC, if offered. Also enter code 2B if the employee is a full-time employee for the month and if their offer of coverage (or coverage if employee was enrolled) ended before the last day of the month because the employee terminated employment during the month.
2C	The employee enrolled in coverage that was offered. Code 2C should not be used if code 1G is used on Line 14 for all 12 months. Code 2C should not be used for any coverage that was not MEC.
2D	The employee is in a Section 4980H(b) limited non-assessment period (initial measurement period applies).
2E	Multi-employer interim rule relief.
2F	Section 4980H(b) Affordability Form W-2 Safe Harbor (must be used for all months of the calendar year for which the employee is offered health coverage).
2G	Section 4980H(b) Federal Poverty Level (FPL) Safe Harbor.
2H	Section 4980H(b) Rate of Pay Safe Harbor.
2I	Reserved.

Note: An affordability safe harbor code should not be entered on line 16 for any month that the ALE member did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents.

Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095c.pdf)

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2023 FORM 1095-B AT A GLANCE

A quick reference guide to Form 1095-B

Form 1095-B provides information about individuals who are covered by minimum essential coverage. This guide provides need-to-know details about how employers and/or insurance carriers should complete and transmit the form, should they choose to file Forms 1095-B.

Form 1095-B: The Basics

In general, small employers offering employer sponsored self-insured group health plans who are not subject to the employer mandate (employer shared responsibility provisions) and health insurance issuers and carriers use Form 1095-B to report information about covered individuals. In most cases, Applicable Large Employer (ALE) Members who offer self-insured group health plans must report information about coverage on Part III of Form 1095-C. However, these ALE Members may furnish Form 1095-B to non-employees who enroll in self-insured health coverage and individual coverage HRAs.

How to complete Form 1095-B

There are four sections to Form 1095-B:

1. **Part I – Responsible Individual:** Provides demographic information about the responsible individual.
2. **Part II – Information About Certain Employer-Sponsored Coverage:** Identifies information about the employer that provides coverage in certain cases.
3. **Part III – Issuer or Other Coverage Provider:** Identifies information about employers reporting self-insured group health plan coverage.
4. **Part IV – Covered Individuals:** Identifies individuals who had coverage for any month during the calendar year.

Additional Information About Form 1095-B:

5. **Line 8:** Enter the Origin of Health Coverage. Refer to IRS instructions for additional detail. Insurance companies that enter codes A or B on Line 8 will complete Part II. Employers reporting self-insured group health plan coverage on Form 1095-B should enter code B on Line 8, skip Part II, and complete Part III. Employers reporting an employer-sponsored individual coverage HRA should enter code G on Line 8, skip Part II, and complete Part III.

Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095b.pdf)

Form **1095-B**
Department of the Treasury
Internal Re[1] Service

Health Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095B* for instructions and the latest information.

☐ CORRECTED | OMB No. 1545-2252 | **2023**

Part I R (1) ble Individual

1 Name of (1) onsible individual–First name, middle initial, last name: First Name | Middle Intial | Last Name
2 Social security number (SSN) or other TIN: SSN
3 Date of birth (if SSN or other TIN is not available): DOB (mm/dd/yyyy)
4 Street address (including apartment no.): Street Address
5 City or town: City or Town
6 State or province: State or Province
7 Country and ZIP or foreign postal code: Country | ZIP or Postal Code
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . . ▶ (5) B
9 Reserved

Part II I (2) on About Certain Employer-Sponsored Coverage (see instructions)

10 Employ (2) me
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: Country | ZIP or Postal Code

Part III (3) r Other Coverage Provider (see instructions)

16 Name: Demo Corporation
17 Employer identification number (EIN): 55-5555555
18 Contact telephone number: 111-234-5678
19 Street address (including room or suite no.): 1 Main Street
20 City or town: Sample City
21 State or province: GA
22 Country and ZIP or foreign postal code: US | 12345

Part IV (4) d Individuals (Enter the information for each covered individual.)

	(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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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CREATE FORM 1095-C MANUALLY

Create and edit Forms 1095-C manually

CREATE NEW FORM 1095-C

Submission Approval | Submission Review | Submitted Batches | Pending Batches | Batch Hold | Manual Forms

1095-C Manual Forms | 1095-B Manual Forms

Create New 1095-C

Tax Year: 2023 — FEIN: Sample Company 0 (271234561) — EE#: — CREATE

Tip: Employee numbers must be 9 digits or less.

1. Click on 1095-C Manual Forms
   1095-C Manual Forms
2. Select the tax year
   Tax Year: 2023
3. Select the FEIN
   FEIN: Sample Company 1 (581234563)
4. Enter the employee number
   EE#: 123456789
5. Click on Create
   CREATE

COMPLETE NEW FORM 1095-C

Form 1095-C — Employer-Provided Health Insurance Offer and Coverage

Part I Employee — Part II Employee Offer of Coverage — Part III Covered Individuals

ADD DEPENDENT ROW — CREATE FORM

Tip: Select checkbox if completing Part III

6. Fill in Part I
7. Fill in Part II
8. Fill in Part III, if self-insured
9. Click on Create Form
   CREATE FORM

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EDIT MANUALLY CREATED FORM 1095-C

Edit Manually Created 1095-C

1 Employee ID # | First Name | Last Name | SSN (Last 4 digits) | SEARCH 2

▾ Employee Search Results

3

Action	First Name	Last Name	State	City	Employee Number	FEI
🔍	User	One	MO	Example	XXX-XX-6789	100000001

1 Search for a manual form

SSN (Last 4 digits)

2 Click on Search

SEARCH

3 Click on the 'magnifying glass'

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.

☐ CORRECTED — OMB No. 1545-2251 — 2023

Part I Employee — Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name): User, M.I., One	2 Social security number (SSN): XXXXX5555 •••
3 Street address (including apartment no.): 123 Main Street	
4 City or town: Example 4	5 State or province: MO
6 Country and ZIP or foreign postal code: US 12345	
7 Name of employer: Sample Company-1	8 Employer identification number (EIN): 100000001
9 Street address (including room or suite no.): 1 Main Street	10 Contact telephone number: 111-234-5678
11 City or town: Sample City	12 State or province: GA
13 Country and ZIP or foreign postal code: US 12345	

Part II Employee Offer of Coverage — Employee's Age on January 1: Age — 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)		$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
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. ☐

Remove	(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)	5 (d) Covered all 12 months	Jan
🗑	18 User M.I. One	XXXXX5555 •••	DOB (Month/day/year) if SSN unknown	☑	☐
🗑	19 User M.I. Two	XXXXX7777 •••	DOB (Month/day/year) if SSN unknown	☑	☐
🗑	20 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐
🗑	21 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐
🗑	22 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐
🗑	23 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, 6 ...parate instructions. — Cat. No. 60705M

ADD DEPENDENT ROW | SUBMIT CHANGES | UNDO EDITS

4 Edit Part I or Part II

Part I Employee — Part II Employee Offer of — 14 Offer of Coverage (enter

5 Edit Part III, if self-insured

(d) Covered all 12 months ☑

6 Click on Submit Changes

SUBMIT CHANGES

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EDIT MANUALLY CREATED FORM 1095-C

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.

☐ CORRECTED | OMB No. 1545-2251 | 2023

Part I Employee | Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)	7 Name of employer	8 Employer identification number (EIN)
User M.I. One	XXXXX5555 •••	Sample Company-1	100000001

3 Street address (including apartment no.)	9 Street address (including room or suite no.)	10 Contact telephone number
123 Main Street	1 Main Street	111-234-5678

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
Example	MO	US 12345	Sample City	GA	US 12345

Part II Employee Offer of Coverage — Employee's Age on January 1: Age — 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)		$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code													

7

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 ☐

Remove		(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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
🗑	18	User M.I. One	XXXXX5555 •••	DOB (Month/day/year) if SSN unknown	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	19	User M.I. Two	XXXXX7777 •••	DOB (Month/day/year) if SSN unknown	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	20	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	21	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐											
🗑	22	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐											
🗑	23	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐											

8

APPROVE CHANGES | DISCARD CHANGES

'our changes have been saved and are pending approval.

7 Verify changes in blue

Dec
1H

8 Click on Approve Changes

APPROVE CHANGES

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.

☐ CORRECTED | OMB No. 1545-2251 | 2023

Part I Employee | Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)	7 Name of employer	8 Employer identification number (EIN)
User M.I. One	XXXXX5555 •••	Sample Company-1	100000001

3 Street address (including apartment no.)	9 Street address (including room or suite no.)	10 Contact telephone number
123 Main Street	1 Main Street	111-234-5678

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
Example	MO	US 12345	Sample City	GA	US 12345

Part II Employee Offer of Coverage — Employee's Age on January 1: Age — 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)		$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
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 ☐

Remove		(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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
🗑	18	User M.I. One	XXXXX5555 •••	DOB (Month/day/year) if SSN unknown	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	19	User M.I. Two	XXXXX7777 •••	DOB (Month/day/year) if SSN unknown	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	20	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	21	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
🗑	22	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐											
🗑	23	First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown	☐	☐											

9

This form was edited by Test User on 10/28/2023 11:59:21 AM
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9 Form 1095-C is approved

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Changes were approved by Test User on 10/

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CREATE FORM 1095-B MANUALLY

Create and edit Forms 1095-B manually

CREATE NEW FORM 1095-B

Submission Approval | Submission Review | Submitted Batches | Pending Batches | Batch Hold | Manual Forms

1095-C Manual Forms | 1095-B Manual Forms (1)

Create New 1095-B

Tax Year: 2023 (2) FEIN: Sample Company 1 (581234563) (3) EE#: (4) CREATE (5)

If the FEIN does not exist, notify your Account Manager.

Tip: Employee numbers must be 9 digits or less.

1 Click on 1095-B Manual Forms

1095-B Manual Forms

2 Select the tax year

Tax Year: 2023

3 Select the FEIN

FEIN: Sample Company 1 (581234563)

4 Enter the employee number

EE#:

5 Click on Create

CREATE

COMPLETE NEW FORM 1095-B

Form 1095-B — Department of the Treasury, Internal Revenue Service — Health Coverage — ► Do not attach to your tax return. Keep for your records. ► Go to www.irs.gov/Form1095B for instructions and the latest information. — CORRECTED — OMB No. 1545-2252 — 2023

Part I Responsible Individual (6)

1 Name of responsible individual–First name, middle initial, last name: First Name | Middle Intial | Last Name
2 Social security number (SSN) or other TIN: SSN
3 Date of birth (if SSN or other TIN is not available): DOB (mm/dd/yyyy)
4 Street address (including apartment no.): Street Address
5 City or town: City or Town
6 State or province: State or Province
7 Country and ZIP or foreign postal code: Country | ZIP or Postal Code
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): B
9 Reserved

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

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: Country | ZIP or Postal Code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name: Demo Corporation
17 Employer identification number (EIN): 55-5555555
19 Street address (including room or suite no.): 1 Main Street
20 City or town: Sample City
21 State or province: GA

Part IV Covered Individuals (7) (Enter the information for each covered individual.)

	(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	Jan	Feb	Mar
23	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐
24	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐
25	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐
26	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐
27	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B

ADD DEPENDENT ROW | CREATE FORM (8)

6 Fill in Part I

Part I Responsible Individual
1 Name of responsible individual
First Name

7 Fill in Part IV

Part IV Covered Individuals (Enter the
23 First Name

8 Click on Create Form

CREATE FORM

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EDIT MANUALLY CREATED FORM 1095-B

1 Employee ID # | First Name | Last Name | SSN (Last 4 digits) 2 SEARCH | ADVANCED OPTIONS

Action	First Name	Last Name	State	City	Employee Number	FEIN
3	User	One	MO	Example	XXX-XX-6789	55-5555555

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

Health Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095B* for instructions and the latest information.

Part I Responsible Individual 4

1 Name of responsible individual–First name, middle initial, last name			2 Social security number (SSN) or other TIN
User	Middle Intial	One	XXX-XX-5555
4 Street address (including apartment no.)	5 City or town		6 State or province
123 Main Street	Example		MO
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . . ▶ B			9 Reserved

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name

12 Street address (including room or suite no.) | 13 City or town | 14 State or province

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
Demo Corporation		55-5555555	111-234-5678
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
1 Main Street	Sample City	GA	

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

	(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	Jan	Feb	Mar	Apr
23	User	M.I.	One	XXX-XX-5555	DOB (mm/dd/yyyy)	☑	☐	☐	☐	☐
24	User	M.I.	Two	XXX-XX-7777	DOB (mm/dd/yyyy)	☑	☐	☐	☐	☐
25	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐
26	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐
27	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B

ADD DEPENDENT ROW | SUBMIT CHANGES 5 | UNDO EDITS

1 Search for a manual form

SSN (Last 4 digits)

2 Click on Search

SEARCH

3 Click on the 'magnifying glass'

4 Correct Part I, III, or IV

Part I Responsible Individual
1 Name of responsible individual–First n
User

5 Click on Submit Changes

SUBMIT CHANGES

APPROVE MANUALLY CREATED FORM 1095-B

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

	(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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	User	M.I.	One	XXX-XX-5555	DOB (mm/dd/yyyy)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	User	M.I.	Two	XXX-XX-7777	DOB (mm/dd/yyyy)	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
25	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										
26	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										
27	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B

APPROVE 7 | DISCARD

6 Verify changes in blue

(d) Covered all 12 months	Jan
☑	☐
☐	☐

7 Click on Approve

APPROVE

Repeat steps 1-3 to search for the approved Form 1095-B.

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

	(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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	User	M.I.	One	XXX-XX-5555	DOB (mm/dd/yyyy)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	User	M.I.	Two	XXX-XX-7777	DOB (mm/dd/yyyy)	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
25	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										
26	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										
27	First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐										

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B

This form was edited by Test User on 10/28/2023 1:13:30 PM
Changes were approved by Test User on 10/28/2023 1:13:30 PM 8

Changes have been saved and approved.

8 Form 1095-B is approved

This form was edited by Test User on 10/28/2023
Changes were approved by Test User on 10/28/20

PRINT

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NON-EMPLOYEE REPORTING FAQS

Answers to your non-employee reporting questions

The IRS offers specific guidance regarding reporting for individuals who are inactive due to termination, retirement, or other reason and are enrolled in employer-sponsored self-insured health plans. This document provides answers to frequently asked questions about non-employee reporting for individuals offered and enrolled in employer-sponsored self-insured health plans.

Who is a non-employee?

For this purpose, any individual who is not actively employed but is offered coverage through an employer-sponsored health plan or an individual coverage HRA is considered a non-employee (e.g. former employees who terminated employment during a previous year, non-employee directors, COBRA beneficiaries, retirees, board members, etc.).

When do employers have to report coverage for non-employees and COBRA participants?

If a non-employee is offered and enrolls in employer-sponsored self-insured coverage, the coverage sponsor (former employer) may report this information on either Form 1095-C or 1095-B to satisfy reporting requirements under 26 U.S. Code § 6055. Additionally, if an active employee loses health coverage due to a reduction in hours, an offer of COBRA coverage is always reported, regardless of whether the plan offered is self-insured or fully insured.

What form should I use to report non-employee coverage?

The IRS has stated either Form 1095-C or 1095-B can be used for non-employee reporting. In most cases, Health e(fx) uses Form 1095-B to report non-employee coverage. However, if an individual transitions from employee to non-employee status during the current reporting year, Health e(fx) will report coverage on Form 1095-C.

How do I report coverage for an employee who terminates employment?

If an employee is not active for any day of the calendar year, Health e(fx) will report enrollment in an employer-sponsored self-insured plan on Part IV of Form 1095-B.

If the employee is terminated during the calendar year, the COBRA qualifying event is not reported as an offer of coverage on Form 1095-C. Instead, codes 1H and 2A in Part II, Lines 14 and 16 respectively, will be used. The former employee or their dependents' enrollment information will be captured on Part III of Form 1095-C.

How do I report a loss of coverage due to reduction in hours?

Unlike a termination of employment, if an employee loses health coverage due to a reduction in hours, the resulting offer of COBRA coverage **is reported as an offer of coverage** in Part II of Form 1095-C. Line 14 will reflect the employee's elected coverage. Line 15 will reflect the COBRA premium for the lowest cost self-only plan. If the employee enrolled in COBRA coverage, code 2C can continue to be used on line 16. If the employee did not elect COBRA, line 16 will either be left blank (most common) or coded with the appropriate affordability safe harbor should the COBRA premium be deemed affordable under section 4980H. Any of the former employee or his/her dependents' enrollment information will be captured in Part III of Form 1095-C.

How do I report coverage of a family member who independently elects COBRA?

Every individual who loses coverage due to a qualifying event has an independent right to elect COBRA. In situations where an employee or former employee does not elect coverage, but a spouse or dependent does, Health e(fx) will either report the elected coverage on Part III of the employee's Form 1095-C or on Part IV of Form 1095-B, depending on the specific scenario.

For detailed information on all reporting, be sure to visit IRS.gov for more information on COBRA retiree reporting and eligibility.

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2023 FORM 1094-C AT A GLANCE

A quick reference guide to Form 1094-C

Form 1094 is a cover sheet that must be transmitted to the IRS along with Forms 1095. Form 1094-C summarizes the data contained on all Forms 1095-C.

Form 1094-C: The Basics

Form 1094-C is used by the IRS to determine whether:

- the ALE Member provided adequate offers of coverage to full-time employees
- employees who received premium tax credits from the Marketplace are eligible for them
- an individual had coverage for the 2023 tax year

Who files Form 1094-C?

Each ALE Member must file at least one Form 1094-C, one of which must be the Authoritative Transmittal (see Part I, line 19). The ALE Member must also file Form 1095-C for every full-time employee who was employed by the ALE Member for any month of the calendar year.

The employer needs to complete either a Form 1095-C or Form 1095-B for non-employees who enroll in employer-sponsored self-funded coverage.

120118

Form **1094-C** Department of the Treasury Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns (I)

▶ Go to www.irs.gov/Form1094C for instructions and the latest information.

CORRECTED

OMB No. 1545-2251

2023

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)
2 Employer identification number (EIN)
3 Street address (including room or suite no.)
4 City or town
5 State or province
6 Country and ZIP or foreign postal code
7 Name of person to contact
8 Contact telephone
9 Name of Designated Government Entity (only if applicable)
10 Employer identificat
11 Street address (including room or suite no.)
12 City or town
13 State or province
14 Country and ZIP or f
15 Name of person to contact
16 Contact telephone
17 Reserved
18 Total number of Forms 1095-C submitted with this transmittal
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructio

Part II ALE Member Information (II)

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member
21 Is ALE Member a member of an Aggregated ALE Group? If "No," do not complete Part IV.

Part III ALE Member Information—Month (III)

	(a) Minimum Essential Coverage Offer Indicator		(b) Section 4980H Full-Time Employee Count for ALE Member	(c) Total Employee C for ALE Member
	Yes	No		
23 All 12 Months	☐	☐		
24 Jan	☐	☐		

120316

Page 3

Part IV Other ALE Members of Aggregated ALE Gro (IV)

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37					

Form 1094-C has four sections:

Part I— Applicable Large Employer Member (ALE Member): Provides demographic information about the ALE Member.

Part II— ALE Member Information (ALE Member): Provides information about the number of submitted Forms 1094-C and eligibility certification.

Part III— ALE Member Information—Monthly: Provides information about employee enrollment counts in a breakdown by month.

Part IV— Other ALE Members of Aggregated ALE Group: Lists other ALE Members within the Aggregated ALE group.

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FORM 1094 FILING

Review and approve Forms 1094 to file with ease

CREATE NEW REVIEW

1 Please create a title for future reference
Tax Year: 2023
Type: Electronic Filing

2 Title:

Please select which forms to review
1094-B/C: Federal CA DC NJ RI

3 Please select which FEINs to review
Select All Select None

Form type FEINs
Sample Company-1 (100000001)

4 BEGIN NEW APPROVAL

1 Select Tax Year and Type

Please create a title for future reference
Tax Year: 2023
Type: Electronic Filing

2 Title the Review

Title:

3 Select the Appropriate FEINs

FEINs
Sample Company (581519913) Sample Company
Sample Company 3 (581651002) Sample Company

4 Start New Approval

BEGIN NEW APPROVAL

REVIEW FORMS 1094

Create / Select Approval · 1094-C · Approval Summary

View FEIN List | APPROVAL STATUS | Recipient: Federal FEIN: 100000001 In Progress | ◄APPROVAL SELECT | APPROVAL SUMMARY

Form **1094-C** — Department of the Treasury Internal Revenue Service
Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns
► Go to www.irs.gov/Form1094C for instructions and the latest information
CORRECTED — OMB No. 1545-2251 — **2023**

1 Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer): Sample Company-1	2 Employer identification number (EIN): 100000001	
3 Street address (including room or suite no.): 1 Main Street		
4 City or town: Sample City	5 State or province: GA	6 Country and ZIP or foreign postal code: US 12345
7 Name of person to contact: Sample User1	8 Contact telephone number: 111-234-5678	
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: Country, Zip Code
15 Name of person to contact	16 Contact telephone number	

For Official Use Only

17 Reserved
18 Total number of Forms 1095-C submitted with this transmittal
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions

Part II ALE Member Information (ALE Member)
20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member
21 Is ALE Member a member of the Aggregated ALE Group? If "No," do not complete Part IV. ☑ Yes
22 Certifications of Eligibility (select all that apply): ☑ A. Qualifying Offer Method ☐ B. Reserved ☐ C. Reserved ☐ D. 98% Offer Method

Part III ALE Member Information - Monthly

	(a) Minimum Essential Coverage Offer Indicator — Yes	No	(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Reserved
23. All 12 Months	☐	☐			☑	

2 Approved? ◉ Yes ○ No

3 Approved? ○ Yes ◉ No
Comments:
Insert comments explaining error

4 NEXT FEIN ►

1 Verify Accuracy of All Parts

Part I Applicable Large Employer Member (ALE Member)
1 Name of ALE Member (Employer)
Sample Company-1
3 Street address (including room or suite no.)
1 Main Street

2 If All Is Accurate

Approved?
◉ Yes ○ No

3 If Errors Exist

Approved?
○ Yes ◉ No
Comments:
Insert comments explaining error

4 Repeat For All 1094-Cs

NEXT FEIN ►

Repeat 1-4 For 1094-Bs

1094B ►

Continue to Approval

APPROVAL SUMMARY ►

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REVIEW COMPLETED WITH ERRORS

Form Type	Total # of Forms	FEIN	Recipient	Result	Comment
1094-C	2	100000001	CA	Review Form	
1094-C	408	100000004	CA	Review Form	
1094-C	37	100000004	DC	Review Form	
1094-C	7	100000007	DC	Review Form	
1094-C	1	100000001	NJ	Review Form	
1094-C	95	100000004	NJ	Review Form	
1094-C	1	100000004	RI	Review Form	
1094-B	3	100000004	CA	Review Form	
1094-B	1	100000004	NJ	Review Form	
1094-C	81	100000001	Federal	Approved	
1094-C	27	100000003	Federal	Approved	
1094-C	3599	100000004	Federal	Approved	
1094-C	127	100000007	Federal	Approved	

Incorrect Data
One or more data item(s) have been marked as incorrect.
Please review all items marked "Review Form" in the list above.

BEGIN NEW APPROVAL

1 If Errors Exist

Incorrect Data
One or more data item(s) have been marked as incorrect.
Please review all items marked "No" in the list above.

2 Research and Fix

Form Type	Total # of Forms	FEIN	Recipient	Result
1094-C	2	100000001	CA	Review Form
1094-C	408	100000004	CA	Review Form
1094-C	37	100000004	Federal	Approved

3 Begin New Approval

BEGIN NEW APPROVAL

REVIEW COMPLETED WITHOUT ERRORS

Form Type	Total # of Forms	FEIN	Recipient	Result	Comment
1094-C	81	100000001	Federal	Approved	
1094-C	27	100000003	Federal	Approved	
1094-C	3599	100000004	Federal	Approved	
1094-C	127	100000007	Federal	Approved	
1094-C	52	100000008	Federal	Approved	
1094-C	26	100000009	Federal	Approved	
1094-C	2	100000001	CA	Approved	
1094-C	408	100000004	CA	Approved	
1094-C	37	100000004	DC	Approved	
1094-C	7	100000007	DC	Approved	
1094-C	1	100000001	NJ	Approved	
1094-C	95	100000004	NJ	Approved	
1094-C	1	100000004	RI	Approved	
1094-B	66	100000004	Federal	Approved	
1094-B	3	100000004	CA	Approved	

Actions

- [x] Electronic Filing to Federal
  Name: Test
  Title: Job

- [x] 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 for all associated FEINs.
- [x] Electronic Filing to CA
  Name: Test
  Title: Job
- [x] Electronic Filing to DC
  Name: Test
  Title: Job
- [x] Electronic Filing to NJ
  Name: Test
  Title: Job
- [x] Electronic Filing to RI
  Name: Test
  Title: Job

◀ 1094B | SUBMIT APPROVAL ▶

1 If No Errors Exist

2 Select Each Checkbox

3 Submit and Print

SUBMIT ▶

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