

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

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OMB No. 1545-2252

2014► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.**Part I Responsible Individual (Policy Holder)**

1 Name of responsible individual PersonFirstNm, PersonMiddleNm, PersonLastNm, SuffixNm		2 Social security number (SSN) SSN	3 Date of birth (If SSN is not available) BirthDt
4 Street address (including apartment no.) AddressLine1Txt, AddressLine2Txt	5 City or town CityNm	6 State or province USStateCd or ForeignProvinceNm	7 Country and ZIP or foreign postal code USZIPCd, USZIPExtensionCd or {CountryCd, CountryName}, ForeignPostalCd
8 Enter letter identifying Origin of the Policy (see instructions for codes): PolicyOriginCd → <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Note: This field is not used for Tax Year 2014	

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

10 Employer name BusinessNameLine1Txt, BusinessNameLine2Txt		11 Employer identification number (EIN) EIN	
12 Street address (including room or suite no.) AddressLine1Txt, AddressLine2Txt	13 City or town CityNm	14 State or province USStateCd or ForeignProvinceNm	15 Country and ZIP or foreign postal code USZIPCd, USZIPExtensionCd or {CountryCd, CountryName}, ForeignPostalCd

Part III Issuer or Other Coverage Provider

16 Name BusinessNameLine1Txt, BusinessNameLine2Txt		17 Employer identification number (EIN) EIN	18 Contact telephone number ContactPhoneNum
19 Street address (including room or suite no.) AddressLine1Txt, AddressLine2Txt	20 City or town CityNm	21 State or province USStateCd or ForeignProvinceNm	22 Country and ZIP or foreign postal code USZIPCd, USZIPExtensionCd or {CountryCd, CountryName}, ForeignPostalCd

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
23 PersonFirstNm, PersonMiddleNm, PersonLastNm, SuffixNm	SSN	BirthDt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			CoveredIndividualAnnualInd	JanuaryInd	FebruaryInd	MarchInd	AprilInd	MayInd	JuneInd	JulyInd	AugustInd	SeptemberInd	OctoberInd	NovemberInd	DecemberInd
25															
26															
27															
28				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Cat. No. 60704B

Form **1095-B** (2014)

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse, 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 do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and miscellaneous coverage designated by the Department of Health and Human Services. For more information on minimum essential coverage, see Pub. 974, Premium Tax Credit (PTC).



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 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.



If you don't provide your SSN and the SSNs 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. Miscellaneous minimum essential coverage



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 2014.

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. If your coverage is not 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, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN is not 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, you will receive one or more additional Forms 1095-B that continue Part IV.

Name of responsible individual

PersonFirstNm, PersonMiddleNm, PersonLastNm, SuffixNm

Social security number (SSN)

SSN

Date of birth (If SSN is not available)

BirthDt

Part IV Covered Individuals — Continuation Sheet

(a) Name of covered individual(s) PersonFirstNm, PersonMiddleNm, PersonLastNm, SuffixNm	(b) SSN SSN	(c) DOB (If SSN is not available) BirthDt	(d) Covered all 12 months CoveredIndividualAnnualInd	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
29				JanuaryInd	FebruaryInd	MarchInd	AprilInd	MayInd	JuneInd	JulyInd	AugustInd	SeptemberInd	OctoberInd	NovemberInd	DecemberInd
30															
31															
32															
33				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>