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Form **1094-B**

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

Go to *www.irs.gov/Form1094B* for instructions and the latest information.

OMB No. 1545-2252

2023

1 Filer's name	**2** Employer identification number (EIN)
3 Name of person to contact	**4** Contact telephone number
5 Street address (including room or suite no.)	**6** City or town
7 State or province	**8** Country and ZIP or foreign postal code
9 Total number of Forms 1095-B submitted with this transmittal	

For Official Use Only

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.

Signature | Title | Date

RAA #1607 For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. 41-0852411 1094BT Form **1094-B** (2023)

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Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Cover

Do not attach to your tax return. K
Go to *www.irs.gov/Form1095B* for instructio

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name

4 Street address (including apartment no.) 5 City or town

8 Enter letter identifying Origin of the Health Coverage (see i

Part II Information About Certain Employer-

10 Employer name

12 Street address (including room or suite no.)

Part III Issuer or Other Coverage Provider (s

16 Name

19 Street address (including room or suite no.)

Part IV Covered Individuals (Enter the informa

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or
23	
24	
25	
26	
27	
28	

RAA #1607 For Privacy Act and Paperwork Reduction Act

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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.

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2023

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name		2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ☐		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

Part III Issuer or Other Coverage Provider (see instructions)

16 Name

19 Street address (including room or suite no.)

Part IV Covered Individuals (

(a) Name of covered individual(s) First name, middle initial, last name		
23		
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RAA #1607 For Privacy Act and Paperw

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IMPORTANT TAX RETURN DOCUMENT ENCLOSED