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Form **1094-B**

**Transmittal of Health Coverage Information Returns**

OMB No. 1545-2252

**2023**

Department of the Treasury  
Internal Revenue Service

Go to [www.irs.gov/Form1094B](http://www.irs.gov/Form1094B) for instructions and the latest information.

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**

**Health Coverage**

Department of the Treasury  
Internal Revenue Service

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information.

**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 instructions for codes): . . . . .

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

10 Employer name

12 Street address (including room or suite no.)

**Part III Issuer or Other Coverage Provider** (see instructions)

16 Name

19 Street address (including room or suite no.)

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

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN
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Form **1095-B**

**Health Coverage**

Department of the Treasury  
Internal Revenue Service

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VOID

OMB No. 1545-2252

CORRECTED

**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)

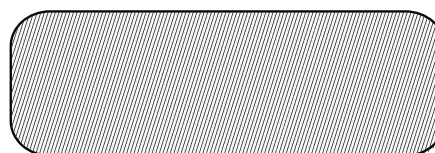
16 Name

19 Street address (including room or suite no.)

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

(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN
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**IMPORTANT TAX RETURN DOCUMENT ENCLOSED**