

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](https://www.irs.gov/Form1095B) for instructions and the latest information.

VOID

CORRECTED

1.20 in

2025

OMB No. 1545-2252

.33 in

.25 in

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)
<div><div>1.8 in</div><div>1.8 in</div><div>1.8 in</div></div>		<div><div>.33 in</div></div>	
4 Street address (including apartment no.)		5 City or town	6 State or province
<div><div>3.5 in</div></div>			7 Country and ZIP or foreign postal code
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		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
	<div><div>1.9 in</div></div>	<div><div>2.1 in</div></div>	<div><div>2.5 in</div></div>

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

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	(e) Months of coverage											
						Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<div><div>.50 in</div></div>		<div><div>.50 in</div></div>	<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					<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"/>
25			<div><div>1.20 in</div><div>.30 in</div><div>.9984 in</div><div>1.20 in</div><div>1.0 in</div></div>		<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"/>
26					<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"/>
27					<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"/>
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"/>	<input type="checkbox"/>

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

Cat. No. 60704B

Form 1095-B (2025) Created 5/28/25

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560118

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

17 Employer identification number (EIN)

18 Contact telephone number

19 Street address (including room or suite no.)

20 City or town

21 State or province

22 Country and ZIP or foreign postal code

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	(e) Months of coverage											
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