

# Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/form1095c](http://www.irs.gov/form1095c) for instructions and the latest information.

☐ VOID  
☐ CORRECTED

OMB No. 1545-2251 600118

**2018**

## Part I Employee

1 Name of employee - First name, middle initial, last name  
**KATHRYN**

**RAMSEY**

2 Social security number (SSN)  
**XXX-XX-2194**

## Applicable Large Employer Member (Employer)

7 Name of employer  
**THE CHILDREN'S HOSPITAL CORPORATION**

8 Employer identification number (EIN)  
**04-2774441**

3 Street address (including apartment no.)

**27 DAN ST**

9 Street address (including room or suite no.)

**300 LONGWOOD AVENUE**

10 Contact telephone number

**617-355-6000**

4 City or town

**WARWICK**

5 State or province

**RI**

6 Country and ZIP or foreign postal code

**US 02889**

11 City or town

**BOSTON**

12 State or province

**MA**

13 Country and ZIP or foreign postal code

**US 02115**

## Part II Employee Offer of Coverage

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)		1A	1A	1A	1A	1A	1A	1A	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2A	2A	2A	2A	2A

## 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
17	KATHRYN RAMSEY	XXX-XX-2194			X	X	X	X	X	X	X					
18	MATTHEW RAMSEY	XXX-XX-0932			X	X	X	X	X	X	X					
19																
20																
21																

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

Cat. No. 60705M

Form 1095-C (2018)

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Name of employee (first name, middle initial, last name)

**KATHRYN**

**RAMSEY**

Social security number (SSN)

**XXX-XX-2194**

## Part III Covered Individuals - Continuation Sheet

	(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
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