

Form **1095-C**  
Department of the Treasury  
Internal Revenue Service

**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  
**2022**

**Part I Employee**

**Applicable Large Employer Member (Employer)**

1 Name of employee (first name, middle initial, last name) <b>MATTHEW</b>	2 Social security number (SSN) <b>***-**-0932</b>	7 Name of employer <b>STATE OF RHODE ISLAND</b>	8 Employer identification number (EIN) <b>05-6000522</b>
3 Street address (including apartment no.) <b>26 LINK LANE</b>		9 Street address (including room or suite no.) <b>ONE CAPITOL HILL</b>	10 Contact telephone number <b>401-574-8530</b>

4 City or town <b>RICHMOND</b>	5 State or province <b>RI</b>	6 Country and ZIP or foreign postal code <b>02892</b>	11 City or town <b>PROVIDENCE</b>	12 State or province <b>RI</b>	13 Country and ZIP or foreign postal code <b>02908</b>
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**Part II Employee Offer of Coverage**

**Employee's Age on January 1**  
**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) <b>1E</b>													
15 Employee Required Contribution (see instructions) <b>\$ 132.30</b>													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>													

**17 ZIP Code**

## 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.

☒[illegible]

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OMB No. 1545-2251

**2022**

**Part I Employee**

1 Name of employee (first name, middle initial, last name) <b>KATHRYN</b>	2 Social security number (SSN) <b>***-**-2194</b>	7 Name of employer <b>STATE OF RHODE ISLAND</b>	8 Employer identification number (EIN) <b>05-6000522</b>
3 Street address (including apartment no.) <b>26 LINK LANE</b>		9 Street address (including room or suite no.) <b>ONE CAPITOL HILL</b>	10 Contact telephone number <b>401-574-8530</b>
4 City or town <b>RICHMOND</b>	5 State or province <b>RI</b>	11 City or town <b>PROVIDENCE</b>	12 State or province <b>RI</b>

**Part II Employee Offer of Coverage**

		Employee's Age on January 1												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)	1E																
15 Employee Required Contribution (see instructions)	\$ 132.30	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C																

17 ZIP Code

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

Cat. No. 60705M

Form **1095-C** (2022)

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.

X

(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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