2020 FORM 1095-B AT A GLANCE

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A quick reference guide to Form 1095-B

Form 1095-B provides information about individuals who are covered by minimum essential coverage. This guide provides need-to-know details about how employers and/or insurance carriers should complete and transmit the form, should they choose to file Forms 1095-B.

Form 1095-B: The Basics

In general, small employers offering employer sponsored self-insured group health plans who are not subject to the employer mandate (employer shared responsibility provisions) and health insurance issuers and carriers use Form 1095-B to report information about covered individuals. In most cases, Applicable Large Employer (ALE) Members who offer self-insured group health plans must report information about coverage on Part III of Form 1095-C. However, these ALE Members may furnish Form 1095-B to non-employees who enroll in self-insured health coverage and individual coverage HRAs.

How to complete Form 1095-B

There are four sections to Form 1095-B:

1. **Part I – Responsible Individual:** Provides demographic information about the responsible individual.
2. **Part II – Information About Certain Employer-Sponsored Coverage:** Identifies information about the employer that provides coverage in certain cases.
3. **Part III – Issuer or Other Coverage Provider:** Identifies information about employers reporting self-insured group health plan coverage.
4. **Part IV – Covered Individuals:** Identifies individuals who had coverage for any month during the calendar year.

Additional Information About Form 1095-B:

5. **Line 8:** Enter the Origin of Health Coverage. Refer to IRS instructions for additional detail. Insurance companies that enter codes A or B on Line 8 will complete Part II. Employers reporting self-insured group health plan coverage on Form 1095-B should enter code B on Line 8, skip Part II, and complete Part III. Employers reporting an employer-sponsored individual coverage HRA should enter code G on Line 8, skip Part II, and complete Part III.

Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095b.pdf)

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.

☐ CORRECTED | OMB No. 1545-2252 | **2020**

Part I Responsible Individual

1 Name of responsible individual–First name, middle initial, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
Faviola	J	Amyot	XXX-XX-8945	01/03/1931
4 Street address (including apartment no.)		**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
10-100 First St		Sample City	NH	US 12345
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): ▶ (5)	B		**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
			Country / ZIP or Postal Code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
Sample Company-1		100000001	212-992-5465
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
10-100 First St Suite #100	Sample City	NY	US 12345

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 Faviola	J	Amyot	XXX-XX-8945	01/03/1931	☐	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐	☐	☐
	24 Bunny	M.I.	Amyot	XXX-XX-7048	05/18/1934	☐	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐	☐	☐
	25 First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	26 First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	27 First Name	M.I.	Last Name	SSN	DOB (mm/dd/yyyy)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B** (2020)