Commonwealth of Massachusetts

REQUEST FOR FORM 1095-C

FOR INTERNAL STATE GOVERNMENT USE ONLY

The Form 1095-C form is the required employer reporting to the Internal Revenue Service (IRS) for Affordable Care Act (ACA) which indicates the status of the employer offer and coverage of employer provided health insurance – Only Part I and Part II for employees who were deemed ACA full-time.

Part II requires monthly reporting for employee offer and coverage of health insurance. No corrections will be made without valid explanation.

Line 15 reports Employee Share of Lowest Cost Monthly Premium, for self-only Minimum Value Coverage. The requestor cannot change dollar amount in this field, can only request if this field needs to be filled or left blank.

There may be a delay in returning the corrected form; and please note that these forms are not needed for filing income taxes.

Instructions:

1. Enter Employee Identification Number (EMPLID)
2. Enter Department Identification Code (DEPTID)
3. Mail a cover letter (dated) with an explanation of why the Form 1095-C correction is being requested together with the Request for a Correction to a Form 1095-C to:

   Office of the State Comptroller
   One Ashburton Place, 9th Floor, Payroll Bureau
   Boston, MA 02108

4. The cover letter must be signed by an authorized signatory.
5. Include a copy of the original Form 1095-C
6. Please include any other documentation relevant to the request and validation for the request.

The Request for a Correction to a Form 1095-C can be either typed or handwritten (make sure boxes are checked when necessary).

With appropriate approval and validation, the Office of the Comptroller will process the Form 1095-C and the employee will be notified via auto generated email using their email address maintained in HR/CMS to retrieve their corrected form via Self-Service.

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<table>
<tr><th colspan="4">Employee Information</th></tr>
<tr><td>Employee ID</td><td>Department ID</td><td colspan="2">Tax Year / Form Corrected

/ 1095-C</td></tr>
<tr><td colspan="2">Employee’s Previously Reported Social Security Number</td><td colspan="2">Employee’s Correct Social Security Number</td></tr>
<tr><th colspan="4">Employee’s Previously Reported Name</th></tr>
<tr><td>Employee’s Previously Reported First Name</td><td>Employee’s Previously Reported Initial</td><td colspan="2">Employee’s Previously Reported Last Name</td></tr>
<tr><th colspan="4">Employee’s Correct Name</th></tr>
<tr><td>Employee’s Correct First Name</td><td>Employee’s Correct Initial</td><td colspan="2">Employee’s Correct Last Name</td></tr>
<tr><th colspan="4">Employee’s Previously Reported Home Address</th></tr>
<tr><td>Street Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><th colspan="4">Employee’s Correct Home Address</th></tr>
<tr><td>Street Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
</table>

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CORRECTION FOR PART II: Complete only fields that are being corrected; all others leave blank.

Employee ID				Department ID		
Months	Previously Reported	Correct Information	Previously Reported	Correct Information	Previously Reported	Correct Information
	Line 14	Line 14	Line 15	Line 15	Line 16	Line 16
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						

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REQUEST FOR FORM 1095-C

REQUIRED: Provide reason for correction. No corrections will be processed without valid explanation.

January
February
March
April
May
June

July
August
September
October
November
December