

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name CHRISTOPHER   C   VIGER JR		<b>2</b> Social security number (SSN) or other TIN 009645648	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1284 MAIN ST		<b>5</b> City or town TURBEVILLE	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29162		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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	
CHRISTOPHER   C   VIGER JR	009645648			X												

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name WILLIAM   M   ROMBILUS III		<b>2</b> Social security number (SSN) or other TIN 180643958	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 3259 ROWE DR		<b>5</b> City or town SUMMERTON	<b>6</b> State or province SC
		<b>7</b> Country and ZIP or foreign postal code USA 29148	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>		<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
		<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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	
WILLIAM	M	ROMBILUS III	180643958		X													
<b>23</b>																		
JESSICA	L	ROMBILUS	232356769		X													
<b>24</b>																		
CAMERON	A	ROMBILUS	882533761		X													
<b>25</b>																		
WILLIAM	M	ROMBILUS IV	657148252		X													
<b>26</b>																		

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name MICHEAL   T   MCLEOD			<b>2</b> Social security number (SSN) or other TIN 247953981	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 2750 TINDAL RD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29150
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)	
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191	<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
MICHEAL   T   MCLEOD <b>23</b>	247953981		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name JAMES   D   NORTON		<b>2</b> Social security number (SSN) or other TIN 248236145	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 2448 HOTEL ST		<b>5</b> City or town ALCOLU	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29001		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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	
JAMES <b>23</b>	D   NORTON	248236145	X													
KAIYA <b>24</b>	L   NORTON	251510290	X													

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name KEVIN   D   JONES			<b>2</b> Social security number (SSN) or other TIN 248251436	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) PO BOX 251		<b>5</b> City or town NORTH	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29112
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017	
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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		
KEVIN   D   JONES	248251436		X														

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

**Health Coverage**  
Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

**Part I Responsible Individual**

<b>1</b> Name of responsible individual-First name, middle name, last name LESLIE   A   DATHER			<b>2</b> Social security number (SSN) or other TIN 248436736	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1817 WATERS EDGE DR		<b>5</b> City or town SUMMERTON	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29148
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

**Part II Information About Certain Employer-Sponsored Coverage** (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

**Part III Issuer or Other Coverage Provider** (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017	
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

**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		
LESLIE <b>23</b>	A	DATHER	248436736		X														
AUBREY <b>24</b>	C	EDWARDS	246979119		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name BRIAN   A   AVINS			<b>2</b> Social security number (SSN) or other TIN 248594133	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 6175 PHOENIX CT		<b>5</b> City or town WEDGEFIELD	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29168
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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	
BRIAN <b>23</b>	A   AVINS	248594133		X	X											

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name CHARLES   D   MOBERG III		<b>2</b> Social security number (SSN) or other TIN 248693185	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1839 GOAT ISLAND RD		<b>5</b> City or town SUMMERTON	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29148		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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	
<b>23</b> CHARLES	D	MOBERG III	248693185		X													
<b>24</b> LINDSEY		MOBERG	249594741		X													
<b>25</b> CHARLES	C	MOBERG	727124410		X													
<b>26</b> CHARLES	D	MOBERG IV	656329378		X													
<b>27</b> MARY	V	MOBERG	535990882							X	X	X	X	X	X	X	X	X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name CHRISTOPHER   M   NIX			<b>2</b> Social security number (SSN) or other TIN 248778249	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 140 MAC RD		<b>5</b> City or town BAMBERG	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29003
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017	
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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		
CHRISTOPHER   M   NIX <b>23</b>	248778249		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name JAMES   R   NORTON			<b>2</b> Social security number (SSN) or other TIN 248873376	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 226 PACK RD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29150
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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		
JAMES 23	R   NORTON	248873376	X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name BRYAN   D   NORTON			<b>2</b> Social security number (SSN) or other TIN 249479614	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1545 BRITTON ROAD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29153
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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		
BRYAN   D   NORTON <b>23</b>	249479614		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name RODNEY   G   HAYDEN		<b>2</b> Social security number (SSN) or other TIN 250934100	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1095 ISLAND DR		<b>5</b> City or town SUMTER	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29154		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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		
RODNEY   G   HAYDEN	250934100		X														

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name LARRY   H   YOUMANS		<b>2</b> Social security number (SSN) or other TIN 251170298	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 455 TURPENTINE STILL RD		<b>5</b> City or town BRUNSON	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29911		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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		
LARRY <b>23</b>	H   YOUMANS	251170298	X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name ROBERT   E   MIMS			<b>2</b> Social security number (SSN) or other TIN 251532540	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 880 OLD MCALLISTER RD		<b>5</b> City or town LAKE CITY	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29560
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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	
ROBERT <b>23</b>	E   MIMS	251532540		X	X	X	X	X								

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name PRESTON   M   EVANS			<b>2</b> Social security number (SSN) or other TIN 251831612	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 3415 BARKLEY RD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29154
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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	
PRESTON   M   EVANS	251831612			X												

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

**Health Coverage**  
 Do not attach to your tax return. Keep for your records.  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

**Part I Responsible Individual**

<b>1</b> Name of responsible individual-First name, middle name, last name NOELAN   N   DATHER			<b>2</b> Social security number (SSN) or other TIN 481981727	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1817 WATERS EDGE DR		<b>5</b> City or town SUMMERTON	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29148
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

**Part II Information About Certain Employer-Sponsored Coverage** (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

**Part III Issuer or Other Coverage Provider** (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148	

**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		
NOELAN   N   DATHER <b>23</b>	481981727		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

**Health Coverage**  
Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

**Part I Responsible Individual**

<b>1</b> Name of responsible individual-First name, middle name, last name BEN   A   WRIGHT			<b>2</b> Social security number (SSN) or other TIN 521451609	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 4950 BETHEL CHURCH RD		<b>5</b> City or town PINEWOOD	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29125
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

**Part II Information About Certain Employer-Sponsored Coverage** (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code		

**Part III Issuer or Other Coverage Provider** (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191	<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

**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	
BEN <b>23</b>	A   WRIGHT	521451609		X	X	X	X	X	X							

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name ANDREW   J   KLUSNER			<b>2</b> Social security number (SSN) or other TIN 602869785	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1810 CAMPBELL CT		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29154
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
ANDREW <b>23</b>	J   KLUSNER	602869785	X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name ALONZO		<b>2</b> Social security number (SSN) or other TIN 654080714		<b>3</b> Date of birth (if SSN or other TIN is not available)	
<b>4</b> Street address (including apartment no.) PO BOX 299		<b>5</b> City or town MANNING		<b>6</b> State or province SC	
<b>7</b> Country and ZIP or foreign postal code USA 29102		<b>9</b> Reserved			
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>					

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849		<b>18</b> Contact telephone number 803-460-1017	
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON		<b>21</b> State or province SC	
<b>22</b> Country and ZIP or foreign postal code USA 29148					

## 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	
ALONZO <b>23</b>	WITHERSPOON 654080714		X													

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name LOGAN   S   MCELVEEN			<b>2</b> Social security number (SSN) or other TIN 654107791	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 4685 TURBEVILLE HWY		<b>5</b> City or town TURBEVILLE	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29162
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)	
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017	
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
LOGAN   S   MCELVEEN	654107791		X														

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name JOSHUA   N   MCLEOD			<b>2</b> Social security number (SSN) or other TIN 656057425	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 2735 TINDAL RD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29150
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148	

## 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		
JOSHUA   N   MCLEOD <b>23</b>	656057425		X														

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name FRANKIE   E   NORTON			<b>2</b> Social security number (SSN) or other TIN 247518100	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 2450 TURNER LN		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29154
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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	
FRANKIE   E   NORTON <b>23</b>	247518100												X			

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name ALLEN   L   PAYTON			<b>2</b> Social security number (SSN) or other TIN 250650089	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 519 WILD BERRY RD		<b>5</b> City or town AIKEN	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29801
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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	
ALLEN   L   PAYTON <b>23</b>	250650089							X	X	X	X	X				

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name LAMONT   J   MADISON		<b>2</b> Social security number (SSN) or other TIN 249438214	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) PO BOX 743		<b>5</b> City or town NORTH	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29112		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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		
LAMONT   J   MADISON	249438214									X							

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name DONALD     RUSSELL		<b>2</b> Social security number (SSN) or other TIN 249470885	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 425 WARLEY RD		<b>5</b> City or town ORANGEBURG	<b>6</b> State or province SC
		<b>7</b> Country and ZIP or foreign postal code USA 29115	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>		<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191	<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
DONALD <b>23</b>	RUSSELL 249470885									X	X						

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

1 Name of responsible individual-First name, middle name, last name NATHAN   B   SUGGS			2 Social security number (SSN) or other TIN 237714845	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 1380 NINETY SIX RD		5 City or town NORTH	6 State or province SC	7 Country and ZIP or foreign postal code USA 29112
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</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	

## Part III Issuer or Other Coverage Provider (see instructions)

16 Name RIGHT WAY TREE EXPERTS LLC		17 Employer identification number (EIN) 831054849	18 Contact telephone number 803-460-1017	
19 Street address (including room or suite no.) PO BOX 191		20 City or town SUMMERTON	21 State or province SC	22 Country and ZIP or foreign postal code USA 29148

## 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	
NATHAN <b>23</b>	B   SUGGS	237714845							X	X	X	X				

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name JONATHAN   R   WILLIAMS		<b>2</b> Social security number (SSN) or other TIN 654033916	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 5588 US HIGHWAY 278		<b>5</b> City or town BARNWELL	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29812		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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	
JONATHAN   R   WILLIAMS <b>23</b>	654033916								X	X						

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name TYLER   D   THARSTON			<b>2</b> Social security number (SSN) or other TIN 655078963	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 148 TUPON LN		<b>5</b> City or town GREEN POND	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29446
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
TYLER   D   THARSTON	655078963									X	X						

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part 1 Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name VINCENT   G   SMITH			<b>2</b> Social security number (SSN) or other TIN 657038071	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 3560 BOLDEN LN		<b>5</b> City or town DALZELL	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29040
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148		

## 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	
VINCENT   G   SMITH	657038071								X	X	X	X	X	X	X	X
<b>23</b>																

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name DAVID   L   BARRETT			<b>2</b> Social security number (SSN) or other TIN 251451341	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 108 BUMPSAS PL		<b>5</b> City or town AIKEN	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29805
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code		

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191	<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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	
<b>23</b> DAVID   L   BARRETT	251451341											X	X	X	X	X
<b>24</b> MARJORIE   A   BARRETT	247577730											X	X	X	X	X
<b>25</b> BRYSON   L   BARRETT	655202813											X	X	X	X	X
<b>26</b> OLIVIA   N   BARRETT	655280035											X	X	X	X	X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name JOHNSON   E   HARRISON		<b>2</b> Social security number (SSN) or other TIN 249972904	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1567 PINEWOOD RD		<b>5</b> City or town SUMTER	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29154		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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	
JOHNSON   E   HARRISON	249972904												X	X	X	X

**23**

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name DUSTY   D   CHESHIRE		<b>2</b> Social security number (SSN) or other TIN 247937152	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 53 GLENWOOD DR		<b>5</b> City or town SUMTER	<b>6</b> State or province SC
<b>7</b> Country and ZIP or foreign postal code USA 29153		<b>9</b> Reserved	
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC
<b>22</b> Country and ZIP or foreign postal code USA 29148			

## 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		
DUSTY <b>23</b>	D   CHESHIRE	247937152														X	
SAWYER <b>24</b>	T   CHESHIRE	824158288														X	

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

**Health Coverage**  
 Do not attach to your tax return. Keep for your records.  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

**2021**

**Part 1 Responsible Individual**

<b>1</b> Name of responsible individual-First name, middle name, last name MELVIN   L   COULTER			<b>2</b> Social security number (SSN) or other TIN 247135804	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 1790 CABELL CT		<b>5</b> City or town SUMTER	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29154
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

**Part II Information About Certain Employer-Sponsored Coverage** (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

**Part III Issuer or Other Coverage Provider** (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC		<b>22</b> Country and ZIP or foreign postal code USA 29148

**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		
MELVIN   L   COULTER <b>23</b>	247135804															X	X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part 1 Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name TYRONE   T   JONES			<b>2</b> Social security number (SSN) or other TIN 251472755	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 672 SALEM BRANCH RD		<b>5</b> City or town NORTH	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29112
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</b>			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)		
<b>12</b> Street address (including room or suite no.)		<b>13</b> City or town	<b>14</b> State or province		<b>15</b> Country and ZIP or foreign postal code

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC			<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017		
<b>19</b> Street address (including room or suite no.) PO BOX 191		<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148		

## 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		
TYRONE   T   JONES	251472755																X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

1 Name of responsible individual-First name, middle name, last name SHERWOOD   H   BROWN			2 Social security number (SSN) or other TIN 654017317	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 899 GRIFFIN ST		5 City or town SUMTER	6 State or province SC	7 Country and ZIP or foreign postal code USA 29154
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): <b>B</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	

## Part III Issuer or Other Coverage Provider (see instructions)

16 Name RIGHT WAY TREE EXPERTS LLC		17 Employer identification number (EIN) 831054849	18 Contact telephone number 803-460-1017	
19 Street address (including room or suite no.) PO BOX 191		20 City or town SUMMERTON	21 State or province SC	22 Country and ZIP or foreign postal code USA 29148

## 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			
SHERWOOD   H   BROWN <b>23</b>	654017317																	X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**  
 Department of the Treasury  
 Internal Revenue Services

# Health Coverage

**Do not attach to your tax return. Keep for your records.**  
 Go to [www.irs.gov/Form1095B](http://www.irs.gov/Form1095B) for instructions and the latest information

VOID  
 CORRECTED

OMB No. 1545-2252

**2021**

## Part I Responsible Individual

<b>1</b> Name of responsible individual-First name, middle name, last name ANGELO   B   JOHSON			<b>2</b> Social security number (SSN) or other TIN 250512190	<b>3</b> Date of birth (if SSN or other TIN is not available)
<b>4</b> Street address (including apartment no.) 924 GRAHAM ST		<b>5</b> City or town ORANGEBURG	<b>6</b> State or province SC	<b>7</b> Country and ZIP or foreign postal code USA 29118
<b>8</b> Enter letter identifying Origin of the Health Coverage (see instructions for codes): B			<b>9</b> Reserved	

## Part II Information About Certain Employer-Sponsored Coverage (see instructions)

<b>10</b> Employer name			<b>11</b> Employer identification number (EIN)	
<b>12</b> Street address (including room or suite no.)	<b>13</b> City or town	<b>14</b> State or province	<b>15</b> Country and ZIP or foreign postal code	

## Part III Issuer or Other Coverage Provider (see instructions)

<b>16</b> Name RIGHT WAY TREE EXPERTS LLC		<b>17</b> Employer identification number (EIN) 831054849	<b>18</b> Contact telephone number 803-460-1017
<b>19</b> Street address (including room or suite no.) PO BOX 191	<b>20</b> City or town SUMMERTON	<b>21</b> State or province SC	<b>22</b> Country and ZIP or foreign postal code USA 29148

## 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		
ANGELO   B   JOHSON	250512190																X

## Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

**Part I. Responsible Individual, lines 1–9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



*If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see [www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals](http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals).*

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16–22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23–28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.