

STATE OF WISCONSIN – 1095-B
PO BOX 5236
JANESVILLE WI 53547 5236



State of Wisconsin

ID #: XXXXXXXXXXXX

1095-B Form Assistance
Phone: 1-866-667-9419

1095B Cover Letter

Mailing Date: MM/DD/YYYY

000000
[MEMBER NAME]
[STREET]
[CITY], WI
[ZIP CODE]



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**Important Tax Information for
[MEMBER NAME]**

The federal government requires the State of Wisconsin to send a 1095-B form to every person in Wisconsin who had health care coverage from BadgerCare Plus, Medicaid, or another State of Wisconsin health care program that provided minimum essential coverage in [TAX YEAR]. Minimum essential coverage is the type of health care coverage a person must have to avoid the federal fee for not having health insurance coverage that is required by the Affordable Care Act.

Enclosed is an IRS 1095-B form for [MEMBER NAME].

If your household files a federal income tax return for [TAX YEAR], you may need to indicate on the tax return whether [MEMBER NAME] had health insurance coverage during all of [TAX YEAR]. The information on the enclosed 1095-B form can help you answer this question.

Note: Each person in your household who had minimum essential coverage through the State of Wisconsin in [TAX YEAR] will get his or her own 1095-B form. Keep in mind that all forms going to the same household may not be mailed on the same day and may not arrive on the same day.

Refer to the instructions on the back of the form for information about using this 1095-B form to complete a tax return. Be sure to keep the form with your other important tax documents. You can also get additional information about this form by visiting irs.gov or contacting a tax professional.

If you have questions about the health care coverage listed on the 1095-B form, please call 1-866-667-9419.

SAMPLE

Form 1095-B Department of the Treasury Internal Revenue Service	Health Coverage	<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED	OMB No. 1545-2252
	► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b		2015

Part I Responsible Individual

1 Name of responsible individual [Member Name]		2 Social security number (SSN) XXX-XX-[NNNN]	3 Date of birth (If SSN is not available) [MM/DD/YYYY]
4 Street address (including apartment no.) [STREET ADDRESS]	5 City or town [CITY]	6 State or province WISCONSIN	7 Country and ZIP or foreign postal code USA [XXXXXX]
8 Enter letter identifying Origin of the Policy (see instructions for codes): ► <input type="checkbox"/> C		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable BLANK	

Part II 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 State of Wisconsin Department of Health Services Division of Health Care Access and Accountability		17 Employer identification number (EIN) 39-6006469	18 Contact telephone number 1-866-667-9419
19 Street address (including room or suite no.) 1 West Wilson Street PO Box 309	20 City or town Madison	21 State or province WI	22 Country and ZIP or foreign postal code USA 53701

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
23 [Member Name]	XXX-XX-[NNNN]	MM/DD/YYYY	<input checked="" type="checkbox"/>	<input type="checkbox"/>												

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption may be liable for the individual shared responsibility payment.

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, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.



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.

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.



If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

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



If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange) that coverage will be reported on a Form 1095-A rather than a Form 1095-B.

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. If your coverage isn't insured employer coverage, this part will be blank.

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, line 23. 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 an SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one 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, you will receive one or more additional Forms 1095-B that continue Part IV.