## Form 1095-A

## **Health Insurance Marketplace Statement**

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OMB No. 1545-2232

2020

Department of the Treasury Internal Revenue Service ▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095A for instructions and the latest information.

CORRECTED
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recipient informs	ation							
1 Marketplace identifier	2 Marketp	3 Policy issuer's r	3 Policy issuer's name					
4 Recipient's name				5 Recipient's SSN	I	6 Recip	6 Recipient's date of birth	
7 Recipient's spouse's name				8 Recipient's spo	8 Recipient's spouse's SSN 9 Recipient's			
10 Policy start date	11 Policy termination date			12 Street address (	12 Street address (including apartment no.)			
13 City or town	14 State or province			15 Country and ZIF	15 Country and ZIP or foreign postal code			
Part II Covered Individua	als							
A. Covered individual name		B. Covered individual SSN		C. Covered individual date of birth			E. Coverage termination date	
16								
17								
18								
19								
20								
Part III Coverage Informa	ation							
Month	A. Monthly enrollment premiums			nly second lowest cos lan (SLCSP) premium	t silver C	C. Monthly advance payment of premium tax credit		
21 January								
22 February								
23 March								
24 April								
<b>25</b> May								
<b>26</b> June								
27 July								
28 August								
29 September								
30 October								
31 November								
32 December								