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Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▸ **Do not attach to your tax return. Keep for your records.**
▸ **Go to *www.irs.gov/Form1095B* for instructions and the latest information.**

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2021

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
KRISTIN	L	BURKLAND	543780543	
4 Street address (including apartment no.)	**5** City or town		**6** State or province	**7** Country and ZIP or foreign postal code
1637 SW OVERTURF AVE	BEND		OR	97702

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ▸ C

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			17 Employer identification number (EIN)	18 Contact telephone number
OREGON HEALTH AUTHORITY			930592162	844-346-8060
19 Street address (including room or suite no.)	**20** City or town		**21** State or province	**22** Country and ZIP or foreign postal code
PO BOX 14015	SALEM		OR	97309-5016

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

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
							Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	KRISTIN	L	BURKLAND	543780543		☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐