1095 Form Request

Instructions:

Complete this form to request a copy of your Form 1095 (Health Coverage Statement). Please provide accurate information to help us locate your record. Submit the completed form to:

MBE
P.O. Box 2339
Fargo, ND 58108-2339

Employee Information

Employer Name: _____

Full Legal Name: _____

Employee ID (if known): _____

Date of Birth (MM/DD/YYYY): _____

Social Security Number (Last 4 digits): _____

Current Mailing Address: _____

City, State, ZIP: _____

Phone Number: _____

Email Address: _____

Request Details

Tax Year Requested (e.g., 2025) _____

*Preferred Delivery Method (check one): ☐ Electronic via employee portal

☐ Mailed paper copy

Acknowledgment

I certify that the information provided above is accurate and authorize the company to release my Form 1095 as requested.

Signature: _____ Date: _____

*Choosing a preferred delivery method here will not update the delivery method currently set on your account. Please contact your employer to make any changes.