



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:

UnifyHR
P.O. Box 2310
Fargo, ND 58108-2310

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) _____

Acknowledgment

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

Signature: _____ Date: _____