

## 2025 Internal Revenue Code Section 6056 Reporting— Employer-Provided Health Insurance

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**Purpose:** Confirms to the Internal Revenue Service (IRS) whether applicable large employers (ALEs) are complying with the Affordable Care Act’s (ACA’s) employer mandate to offer affordable health coverage (or pay a penalty). Section 6056 reporting also identifies individuals who are ineligible for premium tax credits (PTCs) for exchange coverage (i.e., coverage through the ACA’s Health Insurance Marketplace) because they have been offered minimum essential coverage (MEC) by their employer<sup>1</sup>.

### Key forms:

- **IRS Form 1095-C Employer-Provided Health Insurance Offer and Coverage Insurance**—A personalized *IRS Form 1095-C* must be sent to every full-time employee (i.e., 30 hours per week or 130 hours per month) in any month of the calendar year. [If the ALE has a self-insured health plan, it may also send 1095-C forms to any non-employees who were covered (e.g., non-employee director, retiree, etc.) to satisfy Section 6055 reporting requirements.]
- **IRS Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns** (“transmittal form”)—Transmittal form *IRS Form 1094-C* must be sent to the IRS. *IRS Form 1094-C* confirms the total number of *Forms 1095-C* sent. Additionally, the reporting entity must submit to the IRS copies of all *IRS Forms 1095-C*.

**Who must comply:** Section 6056 reporting requires applicable large employers to report to the IRS whether or not “minimum essential coverage” (MEC) was offered.

### Reporting responsibility within the UMC:

Only applicable large employers [employers with 50 or more full-time or full-time equivalent employees (collectively FTEEs)] must complete Section 6056 reporting. Many employers within the UMC are not considered applicable large employers. (See [Employer Shared Responsibility Toolkit—Part 3](#) to determine if a salary-paying unit is an applicable large employer.)

- **For HealthFlex plan sponsors:** Applicable large employers (50 or more FTEEs) who sponsor HealthFlex will need to complete Section 6056 reporting. Section 6056 requires the same information for covered individuals as Section 6055 reporting—plus additional information such as premium amounts. Section 6056 reporting must also be completed for full-time employees who are not covered. Wespath Benefits and Investments (Wespath) has made a good-faith interpretation of IRS guidance to determine that HealthFlex plan sponsors with salary-paying units that are also applicable large employers (50 or more FTEEs) would only need to report the additional information that is not already included in Section 6055 reporting. Therefore, these salary-paying units that are applicable large employers should complete Parts I and II of *IRS Form 1095-C* as described below. These applicable large employers also should complete *IRS Form 1094-C* (transmittal form). As described in [2025 Internal Revenue Code Section 6055 Reporting—Minimum Essential Coverage](#), HealthFlex will complete Section 6055 reporting, which includes coverage information on each individual covered under the HealthFlex group plan.
- **For all other annual conferences with self-insured health plans:** Conference offices and other salary-paying units that are applicable large employers (50 or more FTEEs) must complete Section 6056 reporting (*IRS Forms 1095-C* and *1094-C*). Note that Section 6055 reporting requirements could also be satisfied by completing Section 6056 reporting.
- **For annual conferences sponsoring fully-insured health plans:** Conference offices and other salary-paying units that are applicable large employers (50 or more FTEEs) will have to complete Section 6056 reporting by completing Parts I and II of *IRS Form 1095-C*, as described below. These large employers also should complete *IRS Form 1094-C* (transmittal form). In addition, issuers of the health insurance policies should perform the Section 6055 reporting by completing *IRS Form 1095-B* and *1094-B* (transmittal form).

<sup>1</sup> Note that MEC also includes Health Reimbursement Account (HRA) balances that are not integrated with medical coverage. For example, if a participant terminates coverage but still has an HRA balance available, the HRA balance is still reported as MEC until the balance is depleted.

# Instructions for Completing IRS Form 1095-C for Self-Insured Health Plans

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Form **1095-C**  
Department of the Treasury  
Internal Revenue Service

## Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

VOID

CORRECTED

OMB No. 1545-2251

**2025**

Part I Employee				Applicable Large Employer Member (Employer)									
1 Name of employee (first name, middle initial, last name)		2 Social security number (SSN)		7 Name of employer					8 Employer identification number (EIN)				
3 Street address (including apartment no.)				9 Street address (including room or suite no.)					10 Contact telephone number				
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code			
Part II Employee Offer of Coverage				Employee's Age on January 1					Plan Start Month (enter 2-digit number):				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2025) Created 5/21/25

### Part I – Employee

- Line 1:** Enter name of primary participant (e.g., employee)
- Line 2:** Enter Social Security Number of person entered in Line 1
- Lines 3 – 6:** Enter primary participant's address

### Part I – Applicable Large Employer Member (Employer)

- Line 7:** Enter name of employer
- Line 8:** Enter employer identification number (EIN)
- Line 9:** Enter employer's address
- Line 10:** Enter the telephone number of the person to contact about information reported on *IRS Form 1095-C*
- Lines 11–13:** Enter employer's address

### Part II – Employer Offer and Coverage

#### Note:

- Coverage under HealthFlex meets the requirements of MEC.
- Age:** If the employee was offered an individual coverage HRA, enter the employee's age on January 1, 2025.
- Plan Start Month:** This field is mandatory for 2025 reporting. To complete it, enter the two-digit number (01-12) to indicate the calendar month in which the health plan year begins. If an employee is not offered coverage, enter "00."

**Line 14: Offer of Coverage:** Enter the applicable code for the employee. (If the same code applies for all 12 months of the reporting year, enter the code in the first box. Otherwise enter the applicable code in the box for each corresponding month.)

Report an offer of continuation coverage made to a former employee upon termination of employment by entering Code 1H (No offer of coverage) for any month for which the offer of continuation coverage applies.

Continuation coverage for an active employee (i.e., change to part-time) is reported in the same manner as an offer of that type of coverage to any other active employee.

If an individual was not an employee for the entire year (e.g., was retired or terminated for all 12 months) but was covered, such coverage can be reported using either this *Form 1095-C* or *IRS Form 1094-B* and *1095-B* (i.e., Section 6055 reporting).

**1A** Primary participant offered MEC with minimum value with an annual employee contribution for self-only coverage equal to or less than \$1,358.40 for 2025. In addition, MEC offered to spouse and dependents.

**Note:** If this requirement is met, employee's share of premium amounts does not need to be entered on Line 15.

- 1B** Primary participant offered MEC with minimum value, but this coverage is not offered to spouse or dependents.
- 1C** Primary participant offered MEC with minimum value and at least MEC offered to dependents, but this coverage is not offered to spouse.
- 1D** Primary participant offered MEC with minimum value and at least MEC offered to spouse, but this coverage is not offered to dependents. Do not use Code 1D if 1J applies.
- 1E** Primary participant offered MEC with minimum value. MEC also offered to spouse and dependents. However, the annual employee contribution for self-only coverage was greater than \$1,358.40 for 2025. Do not use Code 1E if 1K applies.
- 1F** MEC is not offered to primary participant, spouse or dependents.
- 1G** Primary participant is not a full-time employee (i.e., works less than 30 hours a week, on average) but is enrolled in the employer’s self-insured coverage. If applicable for all 12 months of the reporting year, enter this code in the “All 12 months” box; otherwise, enter the applicable code in the box for each corresponding month. This code may also be used for employees (and covered dependents) who retired or terminated for the entire year.
- 1H** Primary participant was not offered coverage, or was offered coverage that was not MEC.
- 1I** Reserved
- 1J** MEC providing minimum value offered to primary participant and at least MEC conditionally offered to spouse; MEC not offered to dependents.
- 1K** MEC providing minimum value offered to primary participant; at least MEC offered to dependents; and at least MEC conditionally offered to spouse.
- 1L** ICHRA offered to employee only with affordability determined by using employee’s primary residence location zip code.
- 1M** ICHRA offered to employee and dependent(s) (not spouse) with affordability determined by using employee’s primary residence location zip code.
- 1N** ICHRA offered to employee, spouse and dependent(s) with affordability determined by using employee’s primary residence location zip code.
- 1O** ICHRA offered to employee only using the employee’s primary employment site zip code affordability safe harbor.
- 1P** ICHRA offered to employee and dependent(s) (not spouse) using the employee’s primary employment site zip code affordability safe harbor.
- 1Q** ICHRA offered to employee, spouse and dependent(s) using employee’s primary employment site zip code affordability safe harbor.
- 1R** ICHRA that is NOT affordable offered to employee; employee and spouse or dependent(s); or employee, spouse and dependents.
- 1S** ICHRA offered to an individual who was not a full-time employee.
- 1T** ICHRA offered to employee and spouse (no dependents) with affordability determined using employee’s primary residence ZIP code.
- 1U** ICHRA offered employee and spouse (no dependents) using employee’s primary employment site ZIP code affordability save harbor.
- 1V-1Z** Reserved for future use.

**Line 15:** Enter the employee’s share of the lowest-cost monthly premium for self-only MEC providing minimum value that was offered by the employer. The amount reported is not necessarily the amount paid by the employee (i.e., if they chose a different benefit option or coverage tier). Premium information should only be entered if one of codes 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T or 1U was entered on Line 14. If the employer pays the entire premium, report “0.00” for the employee’s share.

**Line 16:** The following codes indicate whether or not a participant was covered in a month (or if not covered, the reason why). If no codes apply, the employer will be subject to a penalty. Enter only one applicable code, if any, with regard to the primary participant for each month:

- 2A** Enter code if employee was not employed any day of the month even if he or she elected continuation coverage. Do not use this code for any month in which the employee was employed at least one day of the month.
- 2B** Enter this code if one of the following conditions apply:
- Part-time employee (i.e., works less than 30 hours per week) offered coverage, but did not enroll in the coverage.
  - Full-time employee whose offer of coverage or enrollment in coverage ended before the last day of the month solely because the employee terminated employment during the month.
- 2C** Enter this code for any month in which the employee was covered for each day of the month. Use this code even if another code for Line 16 might also apply.
- 2D** Enter this code for any month in which the employee is not enrolled because:
- The participant is subject to a waiting period as elected on the plan sponsor’s adoption agreement.
  - The participant’s date of hire is not the first day of the month, and he or she was only covered for a portion of the month.
- 2E** This code should not apply, as it relates to multi-employer plans.  
Enter one of the following codes (2F, 2G or 2H), if applicable, for employees who were offered health coverage but did not enroll in the coverage:
- 2F** The employer relied on the employee’s income reported on tax form *W-2* to determine if coverage was “affordable.” As long as the cost of coverage to an employee under an employer’s plan does not exceed 9.02% of *W-2* compensation (determined employee-by-employee at the end of the year), an applicable large employer will not be subject to a penalty even if the employee receives a premium tax credit.
- 2G** The employer-based affordability on the federal poverty level (FPL). Under this method, coverage from an applicable large employer is deemed affordable if the cost of coverage for an employee does not exceed 9.02% of FPL for a single person.
- 2H** The employer relied on an employee’s “rate of pay” to determine if coverage was affordable. As long as the hourly rate of pay for an employee (at the beginning of the plan year) multiplied by 130 hours per month does not exceed 9.02% of this amount, the applicable large employer will not be subject to a penalty even if the employee receives a premium tax credit.
- 2I** Reserved
- Line 17:** This line reports the applicable ZIP code the plan sponsor used for determining affordability if the participant was offered an individual coverage HRA. If code 1L, 1M, 1N or 1T was used on line 14, this will be the primary residence location. If code 1O, 1P, 1Q or 1U was used on line 14, this will be the primary work location.

### Part III – Covered Individuals

If self-insured coverage is provided, check the box indicating self-insured coverage is provided.

**Line 18:** Enter the following information for the primary participant

- A** Name
- B** Social Security Number
- C** Date of birth (if SSN not reported)
- D** Check box if primary participant was covered for at least one day in each month of the entire year. Proceed to 17E if primary participant was not covered in all 12 months.
- E** If 17D was not completed, check the box(s) corresponding to each month in which the primary participant was covered for at least one day.

**Lines 19–30:** Enter the following information for each covered dependent of the primary participant

- A** Name of dependent
- B** Social Security Number of dependent
- C** Date of birth (if SSN not reported)
- D** Check box if dependent was covered for at least one day in each month of the entire year. Proceed to 17E if dependent was not covered in all 12 months.
- E** If 17D was not completed, check the box(es) corresponding to each month in which the dependent was covered for at least one day.

# Instructions for Completing *IRS Form 1094-C* for Self-Insured Health Plans

120118

Form <b>1094-C</b> Department of the Treasury Internal Revenue Service	<b>Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns</b> Go to <a href="http://www.irs.gov/Form1094C">www.irs.gov/Form1094C</a> for instructions and the latest information.	<input type="checkbox"/> CORRECTED OMB No. 1545-2251 <b>2025</b>
<b>Part I Applicable Large Employer Member (ALE Member)</b>		
1 Name of ALE Member (Employer)		2 Employer identification number (EIN)
3 Street address (including room or suite no.)		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number
17 Reserved		
18 Total number of Forms 1095-C submitted with this transmittal		
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions		
<b>Part II ALE Member Information</b>		
20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member		
21 Is ALE Member a member of an Aggregated ALE Group? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," do not complete Part IV.		
22 Certifications of Eligibility (select all that apply):		
<input type="checkbox"/> A. Qualifying Offer Method <input type="checkbox"/> B. Reserved <input type="checkbox"/> C. Reserved <input type="checkbox"/> D. 98% Offer Method		
Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.		
Signature	Title	Date
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. <span style="float:right">Cat. No. 61571A Form 1094-C (2025) Created 5/21/25</span>		

- Line 1:** Enter the plan sponsor’s complete name
- Line 2:** Enter the plan sponsor’s Employer Identification Number (EIN)
- Lines 3–6:** Enter the plan sponsor’s complete address where all correspondence will be sent. If mail is delivered to a P.O. Box and not a street address, enter the box number instead of the street address.
- Lines 7–8:** Enter the name and telephone number (including area code) of the plan sponsor contact who is responsible for answering any questions
- Lines 9–14:** Do not complete
- Lines 15–16:** Enter the name and telephone number of plan sponsor contact who is responsible for answering any questions
- Line 17:** Reserved
- Line 18:** Enter the total number of *Forms 1095-C* that are transmitted with *Form 1094-C*
- Lines 19:** Refer to ***Employer Shared Responsibility-Controlled Groups (local churches) or Employer Shared Responsibility-Controlled Groups (annual conferences)*** to determine if you as an employer are part of a controlled group.
  - If the plan sponsor is not part of a controlled group, check this box and proceed to Line 20.
  - If the plan sponsor is part of a controlled group, one organization of the controlled group should check this box and provide aggregate information for the entire group on this form. Proceed to Line 20.
  - Remaining organizations of the controlled group should leave this box blank, sign and date the form, and submit the form along with the *IRS Forms 1095-C* indicated on Line 18.
- Line 20:** Enter the total number of *IRS Forms 1095-C*. This includes all *IRS Forms 1095-C* that are filed with this transmittal, and for any *Forms 1095-C* filed with a separate transmittal.
- Line 21:**
  - If the plan sponsor was not part of a controlled group for all 12 months of the calendar year, check “No.”
  - If the plan sponsor is part of a controlled group any month of the year, check “Yes.” You must complete Part III Column D and Part IV.

**Line 22:** Check the applicable box(es) for each of the offer methods and/or one of the forms of transition relief the plan sponsor is using. The offer methods provide a way to simplify reporting. The transition relief may alleviate penalties from the employer mandate or provide transitional methods of reporting.

**A** **Qualifying Offer Method:** The plan sponsor made a “Qualifying Offer,” which is an offer of minimum essential coverage providing minimum value for all months during the year in which an employee was a full-time employee (unless a waiting period or other exemption from the penalty applies). The cost of a Qualifying Offer to the employee for self-only coverage can be no more than 9.02% of federal poverty level for a single person (\$1,358.40 for 2025), and the plan sponsor must also offer minimum essential coverage to the employee’s spouse and dependents, if any.

**B** Reserved

**C** Reserved

**D** **98% Offer Method:** The plan sponsor offered, for all months of the calendar year, affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a *Form 1095-C* and minimum essential coverage to their dependents. Coverage is considered affordable if:

- The employer relied on the employee’s income reported on tax form *W-2* to determine if coverage was “affordable.” As long as the cost of coverage to an employee under an employer’s plan does not exceed 9.02% of *W-2* compensation (determined employee-by-employee at the end of the year), an applicable large employer will not be subject to a penalty even if the employee receives a premium tax credit; or
- The employer-based affordability on the federal poverty level (FPL). Under this method, coverage from an applicable large employer is deemed affordable if the cost of coverage for an employee does not exceed 9.02% of FPL for a single person; or
- The employer relied on an employee’s “rate of pay” to determine if coverage was affordable. As long as the hourly rate of pay for an employee (at the beginning of the plan year) multiplied by 130 hours per month does not exceed 9.02% of this amount, the applicable large employer will not be subject to a penalty even if the employee receives a premium tax credit.

Part III ALE Member Information—Monthly

	(a) Minimum Essential Coverage Offer Indicator		(b) Section 4980H Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Reserved
	Yes	No				
23 All 12 Months	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24 Jan	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
25 Feb	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
26 Mar	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
27 Apr	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
28 May	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
29 June	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
30 July	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
31 Aug	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
32 Sept	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
33 Oct	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
34 Nov	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
35 Dec	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Form 1094-C (2025)

Lines 23 – 35:

**Column A:** Check the “Yes” box for each month (or “All 12 Months”) in which the plan sponsor offered minimum essential coverage to full-time employees and dependents, or qualified for certain types of transition relief:

- If the plan sponsor offered minimum essential coverage to at least 95% of its full-time employees and their dependents for the entire calendar year, check the “Yes” checkbox on Line 23.
- If the plan sponsor offered minimum essential coverage to at least 95% of its full-time employees and their dependents only for certain calendar months, check the “Yes” checkbox for each applicable month.
- For the months, if any, for which the plan sponsor did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents, check the “No” checkbox for each applicable month.
- If the plan sponsor did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents for any of the 12 months, check the “No” checkbox for “All 12 Months”—unless the plan sponsor is eligible for the transition relief below.

**Note:** For purposes of column (a), an employee in a waiting period is not counted in determining whether minimum essential coverage was offered to at least 95% of a plan sponsor’s full-time employees and their dependents.

**Column B:** Enter the number of full-time employees for each month, but do not count any employee in a waiting period. If the plan sponsor selected the 98% Offer Method on Line 22, it is not required to complete column (b).

**Column C:** Enter the total number of employees, including full-time employees and non-full-time employees and employees in a waiting period, for each calendar month. A plan sponsor must choose to use one of the following days to determine the number of employees per month and must use the same day for all months of the year: 1) the first day of each month; 2) the last day of each month; 3) the first day of the first payroll period that starts during each month; or (4) the last day of the first payroll period that starts during each month (provided that for each month that last day falls within the calendar month in which the payroll period starts). If the total number of employees was the same for every month of the entire calendar year, enter that number in Line 23, column (c) “All 12 Months.”

**Column D:** If a plan sponsor indicated that, during any month of the calendar year, it was a member of an Aggregated ALE Group on Line 21, it must complete this column. If the plan sponsor was a member of a controlled group during each month of the calendar year, check the box for "All 12 Months." If the employer was not a member of a controlled group for all 12 months but was a member of a controlled group for one or more months, check the box for each applicable month. If a plan sponsor was a controlled group for one or more months, it must also complete Part IV.

**Column E:** Reserved

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**Part IV Other ALE Members of Aggregated ALE Group**

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

Name	EIN	Name	EIN
36		51	
37		52	
38		53	
39		54	
40		55	
41		56	
42		57	
43		58	
44		59	
45		60	
46		61	
47		62	
48		63	
49		64	
50		65	

Form 1094-C (2025)

**Lines 36–65:** You must complete if Line 21 is checked "Yes." If the employer was a member of a controlled group for any month of the calendar year, enter the name(s) and EIN of up to 30 of the other controlled group members.

**Distribution and Filing Deadlines Section 6056 Reporting**

- *IRS Forms 1095-C* must be provided to individuals no later than **March 2, 2026**, for the 2025 calendar year. Statements may be delivered electronically, but only if consent, notice and other procedure requirements are met.  
**Alternative manner of furnishing statements.** Employers no longer have to automatically send Form 1095-C to individuals. The requirement for furnishing the statement is met if the employer responsible for providing the statements provides clear, conspicuous, and accessible notice on its website that an individual may request a copy of their statement and the copy is timely furnished. For this purpose, the statement is timely furnished if provided to the individual no later than the later of January 31, 2026, or 30 days after the date of the request.
- All *IRS Forms 1095-C* must be submitted to the IRS with *IRS Form 1094-C* no later than **March 2, 2026**. If more than 10 forms are to be submitted, it must be filed electronically by **March 31, 2026**.

Detailed instructions for completing and submitting the forms are available [here](#) and at [www.irs.gov](http://www.irs.gov).

More information about Section 6056 Reporting is available [here](#) and on the Wespeth website ([wespeth.org](http://wespeth.org) > select "Health Care Reform").

**Disclaimer:** This *summary* is provided by Wespeth as a general informational and educational service to its plan sponsors, the annual conferences, plan participants and friends across The United Methodist Church. It should not be construed as, and does not constitute, legal advice nor accounting, tax, or other professional advice or services on any specific matter; nor do these messages create an attorney-client relationship. Readers should consult with their counsel or other professional adviser before acting on any information contained in this document. Wespeth expressly disclaims all liability in respect to actions taken or not taken based on the contents of this document.

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