

Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095C for instructions and the latest information.

VOID
 CORRECTED

OMB No. 1545-0047 600120

2020

Part I Employee		2 Social security number (SSN) ***-**-3441		Applicable Large Employer Member (Employer)				8 Employer identification number (EIN) 38-0549190			
1 Name of employee (first name, middle initial, last name) YOGENDRAKUMAR B PATEL				7 Name of employer FORD MOTOR COMPANY				10 Contact telephone number 800-248-4444			
3 Street address (including apartment no.) 45552 ELMWOOD CIR				9 Street address (including room or suite no.) ONE AMERICAN ROAD TAX OFFICE ROOM 612				13 Country and ZIP or foreign postal code 48126			
4 City or town CANTON		5 State or province MI		6 Country and ZIP or foreign postal code 48188		11 City or town DEARBORN		12 State or province MI		13 Country and ZIP or foreign postal code 48126	

14 Offer of Coverage (enter required code)	Employee's Age on January 1												Plan Start Month (enter 2-digit number): 01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code													

18	(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	June	July	Aug	Sept	Oct	Nov	Dec	
18	YOGENDRAKUMAR B PATEL	***-**-3441			X	X	X	X	X	X	X	X	X	X	X	X	X
19	DARSH PATEL	***-**-9527			X	X	X	X	X	X	X	X	X	X	X	X	X
20	NIHARIKABEN PATEL	***-**-4275			X	X	X	X	X	X	X	X	X	X	X	X	X
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