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 for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251 600120
2020

Part I Employee

Name of employee (first name, middle initial, last name): MUKESH SHANAGONDA
2 Social security number (SSN): ***-**-2895
Street address (including apartment no.): 929 TIGER LN
City or town: CHARLOTEE NORTH CAROLI
5 State or province: NC
6 Country and ZIP or foreign postal code: 28262

Applicable Large Employer Member (Employer)

7 Name of employer: ALLY BANK
8 Employer identification number (EIN): 20-1001796
9 Street address (including room or suite no.): 500 WOODWARD AVE.
10 Contact telephone number: 866-494-8999
11 City or town: DETROIT
12 State or province: MI
13 Country and ZIP or foreign postal code: 48226

Part II Employee Offer of Coverage

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	Dec
4 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
5 Employee Required Contribution (see instructions)	$	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65	$ 104.65
6 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
ZIP Code													

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

Cat. No. 60705M

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If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
										X	X	X	X	X