PXC 0060 43A15 000000464

000017775 J0805873

CAPGEMINI AMERICA INC
333 WEST WACKER D ST 300
CHICAGO, IL 60606

PXCPNA95CPG0000020801A422A704

017775 RO9MJ901 PXC 0060 43A15 000000464
KIRTI BILGAIYAN
11237 PASEO MONTANOSO
69
SAN DIEGO, CA 92127

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

S 017775 RO9MJ901 017775 E

600120

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
2020

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
KIRTI BILGAIYAN	XXX-XX-5053
3 Street address (including apartment no.)	
11237 PASEO MONTANOSO	
4 City or town	5 State or province
SAN DIEGO	CA
6 Country and ZIP or foreign postal code	
USA 92127	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
CAPGEMINI AMERICA INC	22-2575929
9 Street address (including room or suite no.)	10 Contact telephone number
333 WEST WACKER D ST 300	877-736-7534
11 City or town	12 State or province
CHICAGO	IL
13 Country and ZIP or foreign postal code	
USA 60606	

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
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 0.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F												
17 ZIP Code													

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐