

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.

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 CORRECTED

OMB No. 1545-2251 600120

2020

Part I Employee		2 Social security number (SSN) ***-**-7003		Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 75-3236480	
1 Name of employee (first name, middle initial, last name) SHOURABH KUMAR				7 Name of employer TERADATA US INC			
3 Street address (including apartment no.) 11237 PASEO MONTANASO UNIT NUMBER 69				9 Street address (including room or suite no.) 17095 VIA DEL CAMPO			
4 City or town SAN DIEGO		5 State or province CA		6 Country and ZIP or foreign postal code 92127		11 City or town SAN DIEGO	
						12 State or province CA	
						10 Contact telephone number 866-418-5558	
						13 Country and ZIP or foreign postal code 92127	

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	Dec		
15 Employee Required Contribution (see instructions)	\$	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00	\$ 128.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
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	
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