Department of the Treasury		Employ	► Do I	not attach to y	your tax return. Keep f	r your records. CORRECTED					CTED	9	2020						
Part Employee 2 Social security number (SSN) ***-**-1687						Applicable Large Employer Member (Employer) 8 Employer identification number (EIN) 51-0524195											_		
1 Name of employee (f	first name, middle in:	tial, last name)		The Lattice		7 Name of employer JANSSEN RE	SEARCH & DEV	ELOPMENT	LL	C								_	
3 Street address (include	ding apartment no.)					9 Street address (included 920 US ROU	ding room or suite no.) TE 202 P.O.	BOX 300	-			ľ	10 Cont 8 0 0	act telep	hone nu	mber			
Titane of employee (first name, middle initial, last name) SHIVAMKUMAR R SHAH 1 Stere address including apartment no) 50B MURRAY STREET Cityro from Cityro from Cityro from Cityro from All 12 Months Jan Feb Max Apr 4 Offer of Coverage Employee's Age on Janu 4 Offer of Coverage Employee Required domination (see enter required code) 1 A 1 A 1 A 1 A 1				ZIP or foreign postal cod			2 State or province)					ntry and	ZIP or fo		ostal c	ode		
	vee Offer of Co				e's Age on January		F	lan Start Mon	th (ent	er 2-di	git numb	er): 0		, , ,				_	
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4 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A 1A	1н	1н	1	Н		1н		11	1		1н		
5 Employee Required Contribution (see instructions)		s	s s		s s	s	s		5		s		,	5		s			
6 Section 4980H Safe Harbor and Other Relief (enter code, Lapplicable)		20	2C	2C	2C	2C 2C	2В	2A	2	Α		2A		27	1		2A	-	
17 ZIP Code																			
	Paperwork Reduction	on Act Notice, se	e separate instruction	ons.		Cat. No. 60705M		3 1							Form 10	095-C	(2020	1)	
Form 1095-C (202	20)												-		ŀ	.003 Pa	ge 3	- AND THE REAL PROPERTY OF THE PERTY OF THE	
Parill Cove	ered Individuals	- If Employer	provided self-insur	red coverage,	check the box and en	ter the information fo	r each individual enre	olled in coverag	e, incl	uding	the em								
	All 12 Months Jan Feb Mar Apr 1A 1A 1A 1A 1A S S S S S S S S S S S					(b) SSN or other TIN	(c) DOB (if SSN or oth TIN is not available)		Jan	Feb I	Aar Apr			uly Au	_	Oct N	lov De	<u> </u>	
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£1095-0		Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. Go to www.frs.gov/form1095C for instructions and the latest information.									2020 P00750								
Internal America Service				day security number (SSN)			J 60-4	2020											
Employee XXX-XX-1687 That is of employee (first name, middle initial, last name)						7 Name of employer	e Employer Member (Employer)					13-5				moer (EIN)	
SHIVAM Street address (inclu			SHA	H	10 5	ER SQUIBB (
508 MURRAY					- 4	931 GEORGE R	DAD						act teles						
4 City or town 5 State or province 6 Country and ZIP or foreign postal AVENEL NU US 07001						TAMPA	12 S	ate or province L				113	US US	ry and	ZPo	ricre	du bos	nai code	
Partill Emplo	yee Offer of Co	overage		Employee	's Age on January 1		Plan Start Month (e	nter 2-digit num	ber): 0:	1			00	330	234				
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14 Offer of Coverage (enter required code)		1H	1H	1H	18	1H 1H	1A	1A	1A		,	A	1	1	λ	-	1	A	
5 Employee Required Contribution see instructions)	s	s	s	s	5 5		5 5					F							
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7 ZIP Code For Privacy Act and P	aperwork Reduct	ion Act Notice, se	e separate instr	ructions.		Cat. No.	50705M			- 1					Fo	m 10	95-C	(2020)	
Form 1095-C (2020)																5	003 Pa;	20 ge 3	
Covered Individuals If Employer provided self-insured coverage, check the box and enter the information						or each individual enrolled in coverage, including the employee.						(e) Months of Coverage							
	F	(a) Name of cover lirst name, middle in	red individual(s) nitial, last name			(b) SSN or other TIN	(c) DOB (# SSN or other TIN is not available)	(d) Covered all 12 months	Jan Fe	o Mar	Ax	_	_	_	_	ept	og IN	iov Dec	
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