

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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|---|--|---|--|--|--|--|--|--|--|---|--|--|--|
| Part I Employee | | 2 Social security number (SSN) XXX-XX-3244 | | Applicable Large Employer Member (Employer) | | | | 8 Employer identification number (EIN) 82-0544687 | | | | | |
| 1 Name of employee (first name, middle initial, last name) RAJYALAKSHMI MALAPATI | | | | | | 7 Name of employer AMAZON.COM SERVICES LLC | | | | | | | |
| 3 Street address (including apartment no.) 30978 STONE RIDGE DRIVE 11212 | | | | | | 9 Street address (including room or suite no.) PO BOX 81226 | | | | 10 Contact telephone number 866-644-2696 | | | |
| 4 City or town WIXOM | | 5 State or province MI | | 6 Country and ZIP or foreign postal code US 48393 | | 11 City or town SEATTLE | | 12 State or province WA | | 13 Country and ZIP or foreign postal code US 98108 | | | |

| 14 Offer of Coverage (enter required code) | Employee's Age on January 1 | | | | | | | | | | | | Plan Start Month (enter 2-digit number): 04 | | |
|---|-----------------------------|-----|-----|-----|-----|-----|------|------|-----|------|-----|-----|---|----|----|
| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | | |
| 15 Employee Required Contribution (see instructions) | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2D | 2D | 2A | 2A | |
| 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. <input type="checkbox"/> | | | | | | | | | | | | | | | | |
|---|----------------------|--|---------------------------|------------------------|-----|-----|-----|-----|------|------|-----|------|-----|-----|-----|--|
| (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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