

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

1 Name of employee (first name, middle initial, last name) SAGAR KARRI		2 Social security number (SSN) XXX-XX-8058	Applicable Large Employer Member (Employer) AMAZON.COM SERVICES LLC		8 Employer identification number (EIN) 82-0544687
3 Street address (including apartment no.) 2720 152ND AVE NE UNIT 575			9 Street address (including room or suite no.) PO BOX 81226		10 Contact telephone number 866-644-2696
4 City or town REDMOND	5 State or province WA	6 Country and ZIP or foreign postal code US 98052	11 City or town SEATTLE	12 State or province WA	13 Country and ZIP or foreign postal code US 98108

Part II Employee Offer of Coverage

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
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 31.00	\$ 31.00	\$ 31.00	\$ 31.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2C	2C	2C	2C
17 ZIP Code													

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

Cat. No. 60705M

Form 1095-C (2020)

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	SAGAR KARRI	XXX-XX-8058											X	X	X	X	X
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