☐ VOID   ☐ CORRECTED

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.**

OMB No. 1545-2251

2020

Part I	**Applicable Large Employer Member (Employer) (Lines 7-13)** Employer's name, address, and ZIP code	For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

FORTE CONSTRUCTION CORP.
926 LINCOLN AVENUE

HOLBROOK   NY   11741

Employee (Lines 1-6)

Social security number (SSN):   885-40-7917

Contact telephone number: (631) 589-8600

Employee's first name and middle initial   Last name   Suff.
SUNDER P MANNEMALA
21 PATERSON ST

JERSEY CITY   NJ   07307

Employee's address and ZIP code

Employer identification number (EIN):   27-3167155

Part II	**Employee Offer of Coverage**	**Employee 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)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2E												
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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