600118

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.**

☐ VOID

☐ CORRECTED

OMB No. 1545-2251

2019

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
ADINARAYANA KONDREDDI	XXX-XX-5407

3 Street address (including apartment no.)
402 S POPPY LANE

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
GLENDORA	CA	91741

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
3S BUSINESS CORPORATION INC	27-2949464

9 Street address (including room or suite no.)	10 Contact telephone number
11271 RICHMOND AVE	(281) 823-9222 522

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
HOUSTON	TX	77082

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number): **10**

	All 12 Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 129.16	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F												

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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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