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 600120

2020

Part I **Employee**

1 Name of employee (first name, middle initial, last name): MANASA | VINNAKOTA

2 Social security number (SSN): XXX-XX-6844

3 Street address (including apartment no.): 11230 SEWARD PLAZA APT# 2320

4 City or town: OMAHA

5 State or province: NE

6 Country and ZIP or foreign postal code: US 68154

Applicable Large Employer Member (Employer)

7 Name of employer: MOODY'S ANALYTICS INC

8 Employer identification number (EIN): 13-3851829

9 Street address (including room or suite no.): 7 WORLD TRADE CENTER 250 GREENWICH ST

10 Contact telephone number: 2125531197

11 City or town: NEW YORK

12 State or province: NY

13 Country and ZIP or foreign postal code: US 10007

Part II **Employee Offer of Coverage**

Employee's 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)	1E												
15 Employee Required Contribution (see instructions)	$ 116.76	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	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
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