

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 **600320**
2020

| | | | | |
|--|----------------------------------|--|--|---|
| Part I Employee | | 2 Social security number (SSN) ***-**-1135 | Applicable Large Employer Member (Employer) | 8 Employer identification number (EIN) 80-0909020 |
| 1 Name of employee (first name, middle initial, last name) KRANTHI KOMMINENI | | 7 Name of employer EVOQUA WATER TECHNOLOGIES LLC | | |
| 3 Street address (including apartment no.) 607 ALESSIA COURT | | 9 Street address (including room or suite no.) 210 SIXTH AVENUE SUITE 3300 | | 10 Contact telephone number 855-538-7790 |
| 4 City or town MOON TOWNSHIP | 5 State or province PA | 6 Country and ZIP or foreign postal code 15108 | 11 City or town PITTSBURGH | 12 State or province PA |
| | | | | 13 Country and ZIP or foreign postal code 15222 |

| All 12 Months | Employee's Age on January 1 | | | | | | | | | | | | Plan Start Month (enter 2-digit number): 01 |
|--|-----------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---|
| | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | |
| 14 Offer of Coverage (enter required code) | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E |
| 15 Employee Required Contribution (see instructions) | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 | \$ 117.08 |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C |
| 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 checked="" type="checkbox"/> | | | | (e) Months of coverage | | | | | | | | | | | | |
|---|---|----------------------|--|---------------------------|-----|-----|-----|-----|-----|------|------|-----|------|-----|-----|-----|
| 18 | (a) Name of covered individual(s) <small>First name, middle initial, last name</small> | (b) SSN or other TIN | (c) DOB (if SSN or other TIN is not available) | (d) Covered all 12 months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| | | | | | | | | | | X | X | X | X | X | X | X |
| 19 | ARYAN KOMMINENI | | 2019-03-03 | | X | X | X | X | X | X | X | X | X | X | X | X |
| 20 | MONICA RAVULAPALLI | ***-**-5431 | | | X | X | X | X | X | X | X | X | X | X | X | X |
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