CDY 0034 3DF26 000000675

000030080 J0697871

GLOBAL ATLANTIC FINANCIAL COMPAN
4 WORLD TRADE CENTER 51ST FLOOR
NEW YORK, NY 10007

CDYPNA95CPO0000044916A415A513

030091 RO9MHW01 CDY 0034 3DF26 000000675
AJAI SINGH
24 VINE AVENUE
QUINCY, MA 02169

S 030091 RO9MHW01 030091E

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

600120

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
2020

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
AJAI SINGH	XXX-XX-1665
3 Street address (including apartment no.)	
24 VINE AVENUE	
4 City or town	5 State or province
QUINCY	MA
6 Country and ZIP or foreign postal code	
USA 02169	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
GLOBAL ATLANTIC FINANCIAL COMPAN	90-0928452
9 Street address (including room or suite no.)	10 Contact telephone number
4 WORLD TRADE CENTER 51ST FLOOR	812-933-6780
11 City or town	12 State or province
NEW YORK	NY
13 Country and ZIP or foreign postal code	
USA 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)		1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$ 77.58	$ 77.58	$ 77.58	$ 77.58	$ 77.58
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	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. ☒

	(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	AJAI SINGH	XXX-XX-1665		☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒
19	RAJ RANI SINGH	XXX-XX-3601		☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐