

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

Part I Employee		1 Special security number (SSN) 1636	Applicable Large Employer Member (Employer)	8 Employer identification number (EIN) 94-3316478
1 Name of employee (first, middle initial, last name) ANKITA MORADIYA		7 Name of employer GPS SERVICES INC		10 Contact telephone number 856-411-2772x20600
3 Street address (including apartment no.) 1703 E W HWY #300		9 Street address (including room or suite no.) 2 FOLSON STREET		11 Country and ZIP or foreign postal code 94105
4 City or town SILVER SPRING	5 State or province MD	6 Country and ZIP or foreign postal code 20910	11 City or town SAN FRANCISCO	12 State or province CA

14 Offer of Coverage (enter required code)	Employee's Age on January 1												Plan Start Month (enter 2-digit number) 07		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	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.

18	(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		
	ANKITA MORADIYA	***-**-3646														X	X	X
19																		
20																		
21																		
22																		
23																		
24																		
25																		
26																		
27																		
28																		
29																		
30																		