

Initiate Business CheckingSM

December 31, 2021 ■ Page 1 of 4



SUNNY NATURAL PRODUCTS LLC
8486 GALLUP CT
RANCHO CUCAMONGA CA 91739-9257

Questions?

Available by phone 24 hours a day, 7 days a week:

We accept all relay calls, including 711

1-800-CALL-WELLS (1-800-225-5935)

En español: 1-877-337-7454

Online: wells Fargo.com/biz

Write: Wells Fargo Bank, N.A. (114)

P.O. Box 6995

Portland, OR 97228-6995

Your Business and Wells Fargo

Visit wells Fargo.com/digitalbusinessresources to explore tours, articles, infographics, and other resources on the topics of money movement, account management and monitoring, security and fraud prevention, and more.

Account options

A check mark in the box indicates you have these convenient services with your account(s). Go to wells Fargo.com/biz or call the number above if you have questions or if you would like to add new services.

Business Online Banking



Online Statements



Business Bill Pay



Business Spending Report



Overdraft Protection



Statement period activity summary

Beginning balance on 12/1	\$440.00
Deposits/Credits	501.89
Withdrawals/Debits	- 445.00
Ending balance on 12/31	\$496.89

Account number: [REDACTED] 9370

SUNNY NATURAL PRODUCTS LLC

California account terms and conditions apply

For Direct Deposit use

Routing Number (RTN): 121042882

For Wire Transfers use

Routing Number (RTN): 121000248

Overdraft Protection

Your account is linked to the following for Overdraft Protection:

■ Credit Card - XXXX-XXXX-XXXX-8662



Transaction history

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
12/2		Stripe Transfer St-Z1N7H0H3L5E5 Sunny Natural Products	26.88		466.88
12/7		Etsy Inc Deposit 120621 xxxxx8717 Kiranbala Tripathy	0.01		466.89
12/8		Purchase authorized on 12/07 Rapid Reliable Tes Rrtesting.Com NY S301342048649377 Card 8859		400.00	66.89
12/10		Online Transfer Ref #1b0D3L76x2 to Business Card XXXXXXXXXXXX8662 on 12/10/21		35.00	31.89
12/13		Transfer From Tripathy Subhransu on 12/12 Ref # Pp0D436J9M From Subhransu	475.00		506.89
12/31		Monthly Service Fee		10.00	496.89
Ending balance on 12/31					496.89
Totals			\$501.89	\$445.00	

The Ending Daily Balance does not reflect any pending withdrawals or holds on deposited funds that may have been outstanding on your account when your transactions posted. If you had insufficient available funds when a transaction posted, fees may have been assessed.

Monthly service fee summary

For a complete list of fees and detailed account information, see the disclosures applicable to your account or talk to a banker. Go to wellsfargo.com/feefaq for a link to these documents, and answers to common monthly service fee questions.

Fee period 12/01/2021 - 12/31/2021	Standard monthly service fee \$10.00	You paid \$10.00
How to avoid the monthly service fee	Minimum required	This fee period
Have any ONE of the following account requirements		
• Average ledger balance	\$1,000.00	\$423.00 <input type="checkbox"/>
• Minimum daily balance	\$500.00	\$31.89 <input type="checkbox"/>

C1/C1

Account transaction fees summary

Service charge description	Units used	Units included	Excess units	Service charge per excess units (\$)	Total service charge (\$)
Cash Deposited (\$)	0	5,000	0	0.0030	0.00
Transactions	1	100	0	0.50	0.00
Total service charges					\$0.00



Prepared For	SUNNY NATURAL LLC KIRANBALA TRIPATHY
Account Number	8556 2002 8927 8662
Statement Closing Date	12/23/21
Days in Billing Cycle	31
Next Statement Date	01/23/22
Credit Line	\$15,000
Available Credit	\$14,996

For Customer Service Call:
800-225-5935

Inquiries or Questions:
Wells Fargo SBL PO Box 29482
Phoenix, AZ 85038-8650

Payments:
Payment Remittance Center PO Box 77033
Minneapolis, MN 55480-7733

Payment Information

New Balance	\$3.03
Current Payment Due (Minimum Payment)	\$3.03
Current Payment Due Date	01/17/22

If you wish to pay off your balance in full: The balance noted on your statement is not the payoff amount. Please call 800-225-5935 for payoff information.

Account Summary

Previous Balance	\$0.00
Credits	- \$7,735.22
Payments	- \$35.00
Purchases & Other Charges	+ \$7,773.25
Cash Advances	+ \$0.00
Finance Charges	+ \$0.00
New Balance	= \$3.03

Promotional Balance Summary

0% Purchases	\$327.61
--------------	----------

Promotional balance(s) shown with a 0% interest rate do not include any fees or finance charges that may have been assessed with the transaction.

Wells Fargo Cash Back SM Program Summary

Previous Cash Back Balance	\$398.22
Cash Earned this Month	\$73.64
Trades From Other Company Cards	\$0.00
Bonus/Adjustments	\$0.00
Cash Back Balance	= \$0.00
Cash Awarded this Period	\$324.58
Year to Date Cash Back Awarded	\$329.14

Cash Back Notice

Use your Business Card for all of your business expenses plus everyday purchases and get 1.5% Cash Back.

See reverse side for important information.

5596 YTG 1 7 15 211223 0 PAGE 1 of 6 1 0 5921 0200 BXIL 01DQ5596

DETACH HERE

Detach and mail with check payable to "Wells Fargo" to arrive by Current Payment Due Date.

Make checks payable to: Wells Fargo

Account Number	8556 2002 8927 8662
New Balance	\$3.03
Total Amount Due (Minimum Payment)	\$3.03
Current Payment Due Date	01/17/22

00030300003030048562002692786624

Print address or phone changes:

Work ()

Amount Enclosed:



Rate Information

Your rate may vary according to the terms of your agreement.

TYPE OF BALANCE	ANNUAL INTEREST RATE	DAILY FINANCE CHARGE RATE	AVERAGE DAILY BALANCE	PERIODIC FINANCE CHARGES	TRANSACTION FINANCE CHARGES	TOTAL FINANCE CHARGES
PURCHASES Rate scheduled to end 05/2022	0.000%	0%	\$0.00	\$0.00	\$0.00	\$0.00
CASH ADVANCES	23.990%	.06572%	\$0.00	\$0.00	\$0.00	\$0.00
TOTAL				\$0.00	\$0.00	\$0.00

Important Information

TOTAL *FINANCE CHARGE* BILLED IN 2021 \$0.00

Transaction Details

Trans	Post	Reference Number	Description	Credits	Charges
11/21	11/23	F592100AE000TF334	ITEM TRANSFER, ACCT BAL TRANSFER (TF)	500.00	
11/22	11/23	2480394A7SFGAF388	GOOGLE*ADS7568934260 SUPPORT.GOOGLE CA		500.00
11/22	11/23	2480394A7SFGB45Y0	GOOGLE*ADS7568934260 SUPPORT.GOOGLE CA		500.00
11/22	11/23	F592100AE000TF334	ITEM TRANSFER, ACCT BAL TRANSFER (TF)	500.00	
11/22	11/23	F592100AE000TF334	ITEM TRANSFER, ACCT BAL TRANSFER (TF)	500.00	
11/25	11/25	00000000000ATNEWA	BALANCE TRANSFER FOR ACCT ENDING IN 1814		6,773.25
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	59.84	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	350.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/25	11/25	F592100A9000SS329	ADJUSTMENT-PURCHASES	500.00	
11/30	11/30	F592100AE000AF334	*FINANCE CHARGE* PURCHASES REFUND	1.00	
12/10	12/10	7485620AR36HHG0DQ	ONLINE PAYMENT WEST DES MOIN	35.00	
12/23	12/23		WELLS FARGO CASH BACK - CREDIT	324.58	

Wells Fargo News

Take advantage of the features that come with Online Banking:

Messages and alerts: Stay informed about your account with updates sent to your email or mobile phone.

Wells Fargo Card Design Studio® service: Make your card as unique as your business. Customize your card design with this free service.

Automatic Payments: Never miss a payment, avoid late charges and protect your credit rating.

01/04/2021

IRS TREAS 310 DES:XXTAXEIP2
ID:XXXXX2366200989 INDN:TRIPATHY,...



1,200.00

[Edit Description](#)

Type: Deposit

Description: IRS TREAS 310 DES:XXTAXEIP2 ID:XXXXX2366200989
INDN:TRIPATHY, SUBHRANSU K CO ID:XXXXX36072 PPD

Merchant name: [?](#) INTERNAL REVENUE SERVICE [Edit](#)

Merchant information:

Transaction category: [?](#) Income: Deposits [Edit](#)

[Print transaction details](#)

California Physicians Service
DBA Blue Shield of California
PO Box 3008
Lodi, CA 95241

If you have questions, contact Customer Service at the number in
Box 18 of this form or the number on the back of your ID card.

SUBHRANSU TRIPATHY
8486 GALLUP CT
RCH CUCAMONGA, CA 91739-9257

Form 1095-B (2021)

Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

TIP

Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see www.irs.gov/ACA or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Responsible Individual, lines 1-9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage

TIP

If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information About Certain Employer-Sponsored Coverage, lines 10-15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Department of the Treasury
Internal Revenue Service

▶ Do not attach to your tax return. Keep for your records.

▶ Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID
 CORRECTED

2021

Part I Responsible Individual

1 Name of responsible individual - First name, middle name, last name
SUBHRANSU TRIPATHY

2 Social security number (SSN) or other TIN
XXX-XX-2366

3 Date of birth (if SSN or other TIN is not available)

4 Street address (including apartment no.)
8486 GALLUP CT

5 City or town
RCH CUCAMONGA

6 State or province
CA

7 Country and ZIP or foreign postal code
US 91739-9257

9 Reserved

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): ▶ D

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name

11 Employer identification number (EIN)

12 Street address (including room or suite no.)

13 City or town

14 State or province

15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name
CALIFORNIA PHYSICIANS SERVICE
DBA BLUE SHIELD OF CALIFORNIA

17 Employer identification number (EIN)
94-0360524

18 Contact telephone number
888-256-3650

19 Street address (including room or suite no.)
601 12TH STREET

20 City or town
OAKLAND

21 State or province
CA

22 Country and ZIP or foreign postal code
US 94607

Part IV Covered Individuals (Enter the information for each covered individual.)

	(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			
23	SUBHRANSU TRIPATHY	XXX-XX-2366		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	KIRANBALA TRIPATHY	XXX-XX-3924		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	ANIKET TRIPATHY	XXX-XX-1406		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>