-1	
	₹ P Form
	2>
	Ra O
	0 C
1	8 8 <b>C</b> 1
	Tresa C
	New Y

CLARKSBURG

Part III Employee Offer of Coverage

Employee's Age on January 1

Plan Start Month (enter 2-digit number): 01

## **Employer-Provided Health Insurance Offer and Coverage**

CORRECTI	DIOA	

OMB No. 1545-2251

	45-22
	51
N	
_	
	600
	1
	027

Department of the Treasury Internal Review Review	▶ Do not attac ▶ Go to www.irs.gov/F	<ul> <li>Do not attach to your tax return. Keep for your records.</li> <li>Go to www.irs.gov/Form1095C for instructions and the latest information</li> </ul>	r your records. d the latest information.	CORRECTED	
Part I Employee		2 Social security number (SSN) ***-**-7761	Applicable Large Employer Member (Employer)	yer)	8 Employer identification number (EIN) 22-2466421
1 Name of employee (first name, middle initial, last name) RARGHU KUMAR THALVAYAPATI			7 Name of employer BAE SYSTEMS TECHNOLOGY SOLUTIONS & SERVICES INC.	IONS & SERVICES I	NC.
3 Street address (including apartment no.) 22434 BRIGHT SKY DRIVE			9 Street address (including room or suite no.) 11487 SUNSET HILLS RD		10 Contact telephone number 888-900-4223
4 City or town 5 State or province MD		6 Country and ZIP or foreign postal code 11 City or town 20871	11 City or town RESTON VA	ovince	13 Country and ZIP or foreign postal code 20190-5228

		Annual Contract of the Party of	The same of the sa	Name and Address of the Owner, where the Owner, while the									ָרָ קריים
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Uct	Nov	Dec
14 Offer of Coverage (enter required code)		11	1 E	1E	1 E	1E	15	T T	111	1E	11	11	H
Required		126.77	e 126, 77	£ 126. 77	\$ 126.77	\$126.77	\$126.77 \$126.77 \$126.77	\$126.77	\$126.77	\$126.77	\$126.77	\$126.77	\$126.77
6 Section 4980H Safe Harbor and Other Relief (enter code,		E SE	211			2н	2H	2H	2H	2H	2H	2Н	2н
appucacia													
17 ZIP Code	assumet Reduction	n Art Notice, see	separate instruc	tions.		Cat. No. 60705M	30705M					Form 10	Form 1095-C (2021)

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

P00350 Page 3

	Covered Individuals -
(a) Name of covered individual(s)	If Employer provided self-insured coverage, che
(h)	ne box and enter th
SSN or other TIN	e information
(c) DOB (if SSN or other	for each individual enroll
(d) Covered	led in coverage, ir
(e) Months of coverage	ge, 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 Jar
a

Feb | Mar | Apr | May | June | July | Aug | Sept | Oct Nov Dec

19 -à

Part I

Form 1095-C (2021)