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. Co to warm in nov/Form1095C for instructions and the latest information.

OMB No. 1545-2251 **№**0 **№**

Internal Revenue Service	ICe -		GO TO MMM	ils.gov/roim	CHO LOL IIIST	inclions an	Go to www.iis.gov/roim/090C for instructions and the latest information.	ormation.				[•
Part I Employee	oyee						App	Applicable Lar	ge Employ	rge Employer Member (Employer)	(Employe	Ē	
1 Name of employee (first name, middle initial, last name)	e (first name, mi	ddle initial. last n	ame)	2 Social sec	2 Social security number (SSN)		7 Name of employer		ä		8 Emplo	8 Employer identification number (EIN)	number (EIN)
RAJANIKANTH		SRINIVASA	Ä	*	****-1745		KAVO DENTAL TECHNOLOGIES LLC	AL TECHN	OLOGIES L	LC		27-1212783	చ
3 Street address (including apartment no.)	cluding apartme	nt no.)					9 Street address (including room	ncluding room o	or suite no.)		10 Conta	10 Contact telephone number	nber
2800 HISTORIC CIR	CCIR						11727 FRUEHAUF DRIVE	HAUF DRIV	Æ			(949) 899-4103	103
4 City or town	υ	5 State or province		6 Country and	6 Country and ZIP or foreign postal code 11 City or town	ostal code	1 City or town		12 State or province	ince	13 Countr	13 Country and ZIP or foreign postal code	n postal code
MORRISVILLE		NC	C	2	27560-8178	~	CHARLOTTE			NO O		28273	
Part II Employee Offer of Coverage	oyee Offer	of Coverag	je	En	Employee's Age on January 1	ال age on	anuary 1		Plan Start	Plan Start Month (enter 2-digit number): 01	· 2-digit nur	nber): 01	
34	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	fi	1È	Ē	1E	1É	ħ	1Ê	î î	fi	1E
15 Employee Required Contribution (see instructions)	S	\$ 20.00 \$	20.00 \$	20.00 \$	20.00 \$	20.00 s	\$ 20.00 \$	20.00	\$ 20.00 \$	20.00 \$	20.00 \$	\$ 20.00 \$	20.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code	u)							1			1		1
Part III Covered Individuals	red Individ	uals											
-													

23	22	21	20	19	18		
						(a) Name of covered individual(s) First name, middle initial, last name	ii Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.
						(b) SSN or other TIN	red coverage, crieck in
						(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	ie boy diin eillei nii
						all 12 months	e il lonidi
						Jan	011016
						Feb	901 1110
						Mar	INITIA
						Apr	di Cild
						(e) May	1 000
						(e) Months of coverage	ci aye,
						July	ייייייייייייייייייייייייייייייייייייייי
						Aug	100
						Sept	Silpioy
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						Dec	