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Employer-Provided Health Insurance Offer and Coverage

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

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OMB No. 1545-2251

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▶ Go to www.irs.gov/form1095c for instructions and the latest information. nternal Revenue Service Applicable Large Employer Member (Employer) Part I Employee 8 Employer identification number (EIN) 1 Name of employe (first name, middle initial, last name) 2 Social security number (SSN) XXXXX9420 Incenter LLC 47-4192509 Kancharla Pragathi 10 Contact telephone number 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 484-615-7226 30 7th St E 3868 Central Pike, Apt 215 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 13 Country and ZIP or foreign postal code 12 State or 4 City or town province St Paul US 55101 TN Hermitage MN 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

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
4 Offer of Coverage enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E	1H
5 Employee Required Contribution (see Instructions)	\$	\$	\$	\$	s	\$	\$	\$	\$	\$	\$124.91	\$124.91	\$
6 Section 4980H Safe Harbor and Other Relief enter code, if applicable		2A	2A	2A	2A	2A	2A	2A	2A	2D	2F	2В	2A
7 Zip Code													

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orm 1095-C (2021)

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

			(c) DOB (If SSN or	SSN or (d) Covered			(e) Months of Coverage														
(a) Name of covered individual(s)		(b) SSN or other TIN	(c) DOB (If SSN or TIN is not available)	all 12 months		s Ja	n	Feb	Mar	r A	Apr	May	Jun	July	Y.	Aug	Sept			Nov	Dec
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