Internal Revenue Service	Ö	► Go to www.ii	S.gov/ron	► Go to www.ls.gov/r offitesso is made acid the latest illormation.	actions un	a tile lates		ation.	100	100	-W-7-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	S	100	W.		
Part I Employee	yee				11111	N. S. S. B. B. S.	Applicable La	able L		mploy	rge Employer Member	mber ((Employer)	yer)		
1 Name of employee (ANAND	1 Name of employee (first name, middle initial, last name) ANAND GUPTA	name)	2 Social s	2 Social security number (SSN) ****-**-7111		7 Name of employer HIGHPOINT SOLUTION	mployer INT SC	LUTIC		ဂ			8 En	ployer id	er identification no 20-5090442	8 Employer identification number (EIN 20-5090442
3 Street address (including apartment no.)	ding apartment				•	9 Street address (including room	ress (inclu	ding roor	n or suite no.)	no.)			10 Cc	ntact tele	10 Contact telephone number	ımber
1037 KING WAY	*				-	301 E GERMANTOWN	XMA?	MOI	PIKE				21	(91	(913) 228-3222	3222
4 City or town BREINIGSVILLE	5 State or provi	PA	6 Country	6 Country and ZIP or foreign postal code 18031-1482		EAST NORRITON	PRRITO	N	12 Stat	12 State or province PA	PA		13 Co	untry and	ZIP or forei	13 Country and ZIP or foreign postal code 19401
entill Emplo	ee Offer of Cover	ige		Employee's Age on January 1	\ge on Ja	nuary 1	,		Plan	Start	Month	(enter	Plan Start Month (enter 2-digit number): 01	umber): 01	
A	All 12 Months Jan	Feb	Mar	Apr	May	June		July	Aug	ıg	Sept		Oct		Nov	Dec
14 Offer of Coverage (enter required code)	1E	1E	1E	Æ	Æ	i 1E		1E	1E		1E	68 h	Ē	Administration of the second o	Æ	1H
15 Employee Required Contribution (see instructions)	\$ 34.31	\$ 34.31 \$	34.31	\$ 34.31 \$	34.31	\$ 34.31	31 \$	34.31	⊕ 	34.31 \$		34.31 \$	34.31	4	34.31	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	20	20	20	2C	2C	20		2C	2C	O	2C	jar.	2C	10000 1001 1001 1000	2C	2A
17 ZIP Code												i i	9	P4	C 110	
Part III Covere	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	red coverage, c	heck the	box and enter t	he informa	ation for e	ach indi	vidual e	nrolled	in cove	erage, ir	ncluding	the em	ıployee	.» X	
(a) Name of a	(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)	er (d) Covered all 12 months	hs Jan	Feb	Mar	Apr	(e) I	Months of	(e) Months of coverage	Aug	Sept	Oct	Nov Dec
Anand	Gupta	7111	111			X	×	×	×	×	×	×	×	×	\times	×
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form 1095-C (2021)