

Part I Employee **Applicable Large Employer Member (Employer)**

1 Name of employee (first name, middle initial, last name) **ARULMOZHIVARMAN PARTHIBAN** 2 Social security number (SSN) **XXX-XX-9695** 7 Name of employer **IBM CORPORATION** 8 Employer identification number (EIN) **13-0871985**
 3 Street address (including apartment no.) **9300 COIT RD APT 728** 9 Street address (including room or suite no.) **ONE NEW ORCHARD ROAD** 10 Contact telephone number **1-855-901-1222**
 4 City or town **PLANO** 5 State or province **TX** 6 Country and ZIP or foreign postal code **US 75025** 11 City or town **ARMONK** 12 State or province **NY** 13 Country and ZIP or foreign postal code **US 10504**

Part II Employee Offer of Coverage Employee's Age on January 1: **01** Plan Start Month (enter 2-digit number): **01**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	\$ 0.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
17 ZIP Code													

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 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.

	(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	June	July	Aug	Sept	Oct	Nov	Dec				
18	ARULMOZHIVARMAN PARTHIBAN	XXX-XX-9695		X																
19	AARTHY KUPPIUSAMY		10-05-1993	X																
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