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.
► Go to *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251 600120

2021

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
PRERANA SARODE	XXX-XX-7425
3 Street address (including apartment no.)	
130 DESCANSO DR UNIT 374	
4 City or town	**5 State or province**	**6 Country and ZIP or foreign postal code**
SAN JOSE	CA	US 95134

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
APPLE, INC.	94-2404110
9 Street address (including room or suite no.)	**10 Contact telephone number**
ONE APPLE PARK WAY	1-800-473-7411
11 City or town	**12 State or province**	**13 Country and ZIP or foreign postal code**
CUPERTINO	CA	US 95014

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	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 58.63	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
17 ZIP Code													

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	PRERANA	SARODE	XXX-XX-7425		X												
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