1 095	-C	Employer-Provided Health Insurance									OMB No. 1545-2251			
epartment of the Tre	th to your tax return. Keep for your records.			CORRECTED		P 20	2021							
Part E	mployee	_	GO TO WWW	s.gov/ron	n 1095C 10F II	istructions	and the latest	Applicab	e Large Er	nployer M	ember (En	nployer)		
						security number (SSN) 7 Name of employer							n number (EIN)	
					XXX-XX-4390		enVista Corporation					68-0517515		
3 Street address (ii			9 Street address			•••	10 Cor	ntact telephone nu						
225 South St, Apt 2							11555 N Meridian Str		12 State or province		12 Cour	317-208-9100 13 Country and ZIP or foreign postal code		
				6 Country and ZIP or foreign postal code		11 City or town Carmel		IN			46032			
Jersey City NJ Part Employee Offer of Coverage				07307	Employee's Age o					Plan Start Month (Enter 2			TOPIC	
Part II	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
4 Offer of Coverage (enter equired code)	1H	Vait	100	TVICE	7,4									
5 Employee Required Contribution (see	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
nstructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	φ	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	
	Covered Incide Employer properties of covered incidents			rage, check	the box and (c) DOB (if S	(d) C	formation for e		al enrolled in	T		employee.	Nov Dec	
First nam	ne, middle Initial,	al, last name		or other the	not available)		months Jan	Feb Mar						
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