ANKITA MOR		GPS	GPS SERVICES INC																		
Street address (includ	ling apartment no.)		address (including)						10 Contact telephone number 866-411-2772X20600											
171 W JULI	AN ST. A	5 State or province		6 Country and 2	l code 11 City o	OLSOM ST	12 State or province						13 Country and ZIP or foreign postal code								
SAN JOSE		CA	· 	95110			SAN FRANCISCO			CA				94105							
Part II Employ	yee Offer of Co	overage		Employee'	's Age on Janu	ary 1	1			Plan Start Month (enter 2-digit number):				6 07							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July		Aug	Se	pt		Oct	\perp	Nov			Dec	=	
Offer of Coverage																					
enter required code)		1E	1E	1E	1E	1A	1A	1A		la	1	A	+	1A	+	1A			1A		
Employee Required																					
entribution (see estructions)	\$	\$ 82.00	\$ 82.00	\$ 82.00	\$ 82.00 \$	3	\$	\$	\$	\$			\$		\$			\$			
Section 4980H afe Harbor and Other																					
elief (enter code, applicable)		2 c	2C	2C	2C	2C	2C	2C		2C	2	C		2C		2C			2C		
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	Privacy Act and Paperwork Reduction Act Notice, see separate instructions.					Cat. No.	60705M										Form 1	095-C	(202	22)	
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Form 1095-C (2022)																	P	age 3		
Part III Cover	ed Individuals	- If Employer p	rovided self-ins	ured coverage.	check the box a	nd enter the i	nformation for	r each individua	l enrolled	in coverage	e, inc	luding	the em	ployee.	×	{}					
Part III Covered Individuals – If Employer provided self-insured coverage, check the box and (a) Name of covered individual(s)							(b) SSN or other TIN (c) DOB (if SSN			other (d) Covered				(e) Months of coverage							
(a) Name of covered individual(s) First name, middle initial, last name					(3,55		TIN is not avai	ilable) a	all 12 months		Jan Feb Mar		Apr May Jun		e July Aug Se		Oct	Nov	ov Dec		
ANKITA M	ORADIYA					***.	-**-3646				×	×	××	X :	× :	× ×	×	×	X	×	
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											_						Form 1	095-0	C (20	22)	

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.

2 Social security number (SSN)

***-**-3646

1095-C

Part I Employee

1 Name of employee (first name, middle initial, last name)

600120

OMB No. 1545-2251

94-3316478

5055

8 Employer identification number (EIN)

VOID

Applicable Large Employer Member (Employer)

7 Name of employer

CORRECTED