1095-C partment of the Treasur smal Revenue Service	ry		P GO TO WITH.			nd the latest inform	ation.					- 10	Caralan and	202		
art Employ	ee			2 Socia	al security number (SSN)	Applicable La	rge Employer Men	ber (Employe	r)			8	Employer ide	421	number (i	
me of employee (firs AGHU KUMAR	st name, middle init THALVAYA	ial last name) PATI		•			NS TECHNOLOG		ONS	& SEF	RVICE					
Street address (including apartment no.) 22434 BRIGHT SKY DRIVE						9 Street address (including room or suite no.) 2941 FAIRVIEW PARK DRIVE						10	10 Contact telephone number 888-900-4223			
		State or province		6 Country and	6 Country and ZIP or foreign postal code		11 City or town FALLS CHURCH		12 State or province				13 Country and ZIP or foreign posta 22 0 42 - 45 41			
Part II Employee Offer of Coverage			Employee	e's Age on January		Plan Start Month (enter 2-digit number):				or): 01	01					
	All 12 Months	Jan	Feb	Mar	Apr	May June	July	Aug		Sept		Oct	No	IV	D€	
offer of Coverage per required code)		1E	1E	1E	1E :	IE IE	1E	1н	1	1H	-	1Н	1н	-	1н	
Employee Required tribution (see tructions)	\$	s 76.21	s 76.21	s 76.21	s 76.21 s 76	5.21 \$ 76.2	1 \$ 76.21	\$	\$		\$		\$	\$		
Section 4980H e Harbor and Other ief (enter code, oplicable)		2н	2Н	2Н	2н :	2н 2н	2Н	2A	2	?A	2	2A	2A		2A	
		No.														
ZIP Code											-			orm 1095-0	•	
orm 1095-C (202	12)														1320 Page 3	
		s – If Employer p	provided self-ins	sured coverage	, check the box and en	eter the information t	or each individual er	rolled in covera	ge, inc	luding th	ne empl					
		(a) Name o	provided self-ins f covered individua middle initial, last n	l(s)	, check the box and en	eter the information (or each individual er (c) DOB (if SSN or or TIN is not available	her (d) Covered				(e) Month	hs of coverage	9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	
		(a) Name o	f covered individua	l(s)	, check the box and en		(c) DOB (if SSN or of	her (d) Covered				(e) Month		9	Page 3	