

Part I Employee

1 Name of employee (first name, middle initial, last name) VISHWA N SINGH			2 Social security number (SSN) XXX-XX-1449		7 Name of employer AMAZON.COM SERVICES LLC			8 Employer identification number (EIN) 82-0544687				
3 Street address (including apartment no.) 17620 AVALAR AVE					9 Street address (including room or suite no.) PO BOX 81226					10 Contact telephone number 866-644-2696		
4 City or town PFLUGERVILLE		5 State or province TX		6 Country and ZIP or foreign postal code US 78660			11 City or town SEATTLE		12 State or province WA		13 Country and ZIP or foreign postal code US 98108	

Applicable Large Employer Member (Employer)

Part II Employee Offer of Coverage Employee's Age on January 1: _____ Plan Start Month (enter 2-digit number): 04

	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)	\$ 33.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
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 (2022)

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	D	
18	VISHWA N SINGH	XXX-XX-1449		X													
19	RUKMINI	XXX-XX-9827		X													
20	ARIN	XXX-XX-2598		X													
21	ALAI SHA	XXX-XX-8174		X													
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