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

2022

Part I Employee

2 Social security number (SSN) ***-**-0441

Applicable Large Employer Member (Employer)

8 Employer identification number (EIN) 20-2000033

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

7 Name of employer
ZILLOW, INC.

3 Street address (including apartment no.)
15950 PARAMOUNT WAY APT 3425

9 Street address (including room or suite no.)
1301 2ND AVENUE 31ST FLOOR

10 Contact telephone number
206-470-7000

4 City or town
FRISCO

5 State or province
TX

6 Country and ZIP or foreign postal code
75033

11 City or town
SEATTLE

12 State or province
WA

13 Country and ZIP or foreign postal code
98101

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)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
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	SHALENI MEDIKONDA	***-**-0441		X												
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