∄1095-C		Employer-Provided Health Insurance Offer and Coverage										OMB No. 1545-2		001
					ov/Form1095C for instructions and the latest information.				CORRECTED			5055		
Part I Employee				2 Soc	2 Social security number (SSN) ***-**-6813		plicable Large E	nber (Employe	er)		8 Employer identification number (EIN) 31-1343192			
1 Name of employee (first name, middle initial, last name) MANOJ KUMAR REDDY GOPU							7 Name of employer EXPERIAN INFORMATION SOLUTIONS INC.							
3 Street address (including apartment no.) 10636 SMOKY OAK TRL						9 Stre	et address (including 5 ANTON BI	.)			10 Contact telephone number 866-520-3284			
4 City or town ARGYLE		5 State or province TX		6 Country ar 7 6 2 2 5	nd ZIP or foreign postal o		ty or town OSTA MESA		12 State or province CA			13 Country and ZIP or foreign postal co 92 62 6		
Part II Employee Offer of Coverage				Employe	ee's Age on Janua	ry 1			Plan Start Month (enter 2-digit number):			01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June July Aug Sept		Oct	No	. 1	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	11	E
15 Employee Required Contribution (see instructions)	\$	s 161.27	s 161.27	§ 161.27	s 161.27 s	161.2	7 \$ 161.27	s 161.27	\$ 161.27	s 161.27	s 161.	27 s 161.	27 s 161	.27
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	20	20	20	C
17 ZIP Code														
For Privacy Act and Pa	perwork Reducti	on Act Notice, see	separate instruct	ions.		Cat. N	o. 60705M		•				Form 1095-C (2	2022

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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. (e) Months of coverage (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 ali 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov [22 24 25