**Form 1095-C** 600120
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

**2022**

## Part I Employee

| 1 Name of employee (first name, middle initial, last name) | 2 Social security number (SSN) |
| --- | --- |
| SUBRA VEERA RAN THUMMALAPALLI | ***-**-3474 |

3 Street address (including apartment no.): 304 49TH STREET APT 3

| 4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code |
| --- | --- | --- |
| UNION CITY | NJ | 07608 |

**Applicable Large Employer Member (Employer)**

| 7 Name of employer | 8 Employer identification number (EIN) |
| --- | --- |
| MORGAN STANLEY SERVICES GROUP INC, | 26-0116361 |

| 9 Street address (including room or suite no.) | 10 Contact telephone number |
| --- | --- |
| 750 7TH AVE 8TH FLOOR - PAYROLL | 877-674-7411 |

| 11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code |
| --- | --- | --- |
| NEW YORK | NY | 10019-6800 |

## 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 | 1A | 1A | 1A | 1A | 1A | 1A | 1A | 1A | 1H | 1H | 1H |
| 15 Employee Required Contribution (see instructions) | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2A | 2A | 2A |
| 17 ZIP Code | | | | | | | | | | | | | |

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2022)

Form 1095-C (2022)

600320



## Part III Covered Individuals

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 | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 18 | SUBRA VEERA RAN THUMMALAPALLI | ***-**-3474 | | | X | X | X | X | X | X | X | X | X | | | |
| 19 | | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | | |
| 21 | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | |
| 23 | | | | | | | | | | | | | | | | |
| 24 | | | | | | | | | | | | | | | | |
| 25 | | | | | | | | | | | | | | | | |
| 26 | | | | | | | | | | | | | | | | |
| 27 | | | | | | | | | | | | | | | | |
| 28 | | | | | | | | | | | | | | | | |
| 29 | | | | | | | | | | | | | | | | |
| 30 | | | | | | | | | | | | | | | | |

Form **1095-C** (2022)