§1095-C		<b>Employ</b>	er-Prov	ided He	alth Insu	ranc	e Offer ar	nd Cove	rage		VO		TED	9	MB No.	1545-2			
Department of the Treasury  Go to www.irs.gov/Form1095C for instructions						ns and t	or your records.							8	8 Employer identification number (EIN) 13-2695416				
Part I Employ	ree			2 Socia	al security number (S *-**-5733		Applicable Large	Employer Me	ember (E	mployer)					13-	269	5416		. (=::,)
Name of employee (firs SOUMITH REI	st name, middle initia	al, last name) _A				with SERVER FORM	Name of employer ZIMMER INC												
3 Street address (including apartment no.) 1327 TUSCANY XING							9 Street address (including room or suite no.) 345 E MAIN STREET  10 Contact telephone number 877-588-0933										The second second		
4 City or town State or province G Country and ZIP or foreign postal of WARSAW IN 46590					code 11	City or town WARSAW		12 State or province IN					13 Country and ZIP or foreign po 46590				postal cod		
Part II Employee Offer of Coverage					e's Age on Janu	2 Stutkings				lan Start Month (enter 2-digit number				r): 01					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July		Aug	Sept			Oct	No		lov		Dec
Offer of Coverage enter required code)		1A	1A	1A	1A	1A	1A	1A		1A	1	A		1A		1	A		1A
5 Employee Required contribution (see nstructions)	\$	5	\$	\$	\$		\$	\$	\$	\$			\$		\$			\$	, in the second
6 Section 4980H safe Harbor and Other Relief (enter code, applicable)		2C	2C	2C	20	20	20	2C		2C	2	С		2C		2	lC.		2C
7 ZIP Code or Privacy Act and Pa	aperwork Reductio	n Act Notice, see	separate instru	ctions.		Ca	t. No. 60705M										Form	1095-0	(2022)
Form 1095-C (2022	KIND SECTION STATES	- If Employer	omvided self-in	istired coverage	check the box a	od enter	the information for								<u> </u>	×I			1320 Page 3
The second second second	KIND SECTION STATES	(a) Name o	f covered individu	al(s)	, check the box a	SERVICE STREET	the information for	and the second second	SUCCESSION TO	600000000000000000000000000000000000000	e, inc	luding	the em			X of cove	erage		
Part III Cove	red Individuals	(a) Name o First name,		al(s)	, check the box a	(I	o) SSN or other TIN	each individua (c) DOB (if SSN TIN is not ava	or other	in coverag (d) Covered Il 12 months	Jan	Feb N	lar Apr	(e) M May	June J	of cove	ug Se	pt Oct	Page 3
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