

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) ***-**-5733		Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 13-2695416	
1 Name of employee (first name, middle initial, last name) SOU MITH REDDY VODNALA				7 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			
4 City or town WARSAW		5 State or province IN		6 Country and ZIP or foreign postal code 46590		11 City or town WARSAW	
						12 State or province IN	
						13 Country and ZIP or foreign postal code 46590	

14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)												16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov		Dec
		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C

17 ZIP Code

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 1095-C (2022)

18 (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
SOU MITH REDDY VODNALA		***-**-5733			X	X	X	X	X	X	X	X	X	X	X	X
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