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

OMB No. 1545-2251 9000

	ployee					The state of the s	actions an									1	4	22			
Name of employee (first name, middle initial, last name) SANTOSH MAHENDRA					2 Socia	I security number (SS	SN)	Applicable Large Employer Member (Employer)													
3 Street address (including apartment no.)						****-**-0673			7 Name of employer SALESFORCE.COM INC								8 Employer identification number (EIN)				
38025 CONRAD ST								9 Street add			e no)			10	94-3320693						
4 City or town						2 and 710 .	1.3	415 MISS		10 Contact telephone number (855) 376-5627											
MONT					Coding	6 Country and ZIP or foreign postal code 94536-3923						12 State or province					13 Country and ZIP or foreign postal code				
Part Employee Offer of Coverage						Employage 4	- !	SAN FRANCISCO			CA					94105					
All 10 Months		Feb	Mar	Apr Apr	age on Ja			Plan Start Month (enter 2					-digit number): 01								
14 Offer of Coverage (enter			1E	15	45	·	May	June 1E		July	P	Aug Sept			Oct		Nov	С	Dec		
required code)			IE	1E	1E	1E	1E			1E	1E		1E		1E		1E		1E		
Required	5 Employee Required						1												12		
Contribution (see instructions)	\$	s 0.00 s		0.00	\$ 0.00	0.00		9 50													
16 Section 4980H	<u> </u>	5 0.00 \$		0.00	φ 0.00	0 \$ 0.00 \$	0.00	\$ 0.00		0.00	\$ 0.00		\$ 0.00		0.	00 s	0 \$ 0.00		\$ 0.00		
Safe Harbor and Other Relief (enter		2		2C	2C	2C	20	2C			2C		2C								
code, if applicable)						20	2C			2C					2C		2C		2C		
17 ZIP Code																					
Part III Covered Individuals																					
If Er	mployer p	rovide	d self-insur	ed coverage	e, check the	e box and enter t	the informa	ation for e	ach ind	dividual e	enrolle	d in cov	ierade	includir			Г	1			
If Employer provided self-insured cov (a) Name of covered individual(s) First name, middle initial, last name			(b) SSN o	r other TIN	(C) DOB (II SSN or oth	er Id) Covere	ed			(e) Months of coverage					the employee.						
Thistrian	re, middle ini	Tial, last	name			TIN is not available)	ail 12 mont	ths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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Hewlett Packard Enterprise Company 1701 EAST MOSSY OAKS ROAD SPRING, TX 77389

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Form 1095-C	1		e C	e Offer and						\vdash	OMB No. 1545-2251									
Form 1033-C				•							□ ∧OID				20	^				
Department of the Treasury						Geep for your records one and the latest information.						☐ CORRECTED				2022				
Internal Revenue Ser			F G0	to www.irs.gc	DV/F UI II	110950 10	TISU UCUOIS	alu ur						- NA	mhor	/Emr	lover	٠,		
Part Employee 1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)								Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (EIN)												
Prathyusha	e (first name,	, middle initial, Vemula	,							oyer d Enterpris	se Compa	47-3298624								
3 Street address (in 38025 Conrad St						9 Street address (including apartment no.) 1701 EAST MOSSY OAKS ROAD								10 Contact telephone number 8445375304						
4 City or town	5 State or pr	ovince	6 Country code	and ZIP or foreign postal			11 City or town						12 State or 13 Cour			try and ZIP or foreign postal				
Fremont	Fremont CA			USA 945	536			SPRING					TX		USA 77389					
Part II Em	ployee C	ffer and	Coverag	je	e Employee's A					/1		Plan Start M								
14 Offer of	All 12 Month	ns Jan	Feb	Ma	ar	Apr	May	Jun		Jul	/	Aug		pt	Oct		Nov		Dec	
Coverage (enter required code) 1A																				
15 Employ ee																				
Required Contribution (see instructions)	\$	\$	\$	\$	\$		\$	\$	\$	5	\$		\$		5	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2G																			
17 ZIP Code	17 ZIP Code															\perp				
Part III Cov	ered Ind	ividuals	If Employer	provided sef-in	nsured co	overage, chec	k the box and	enter the i	informa	tion for eac	ch individu	ial enrol	led in cov	erage, i	ncludingth	e employ	yee.	ΙX		
(a) Name of covered ind			b) SSN or ot	her TIN		OB (If SSN other TIN is	(d) Covered					(e)	Months	of cover	rage					
name, middle initial, last name		,	0) 3311 0 0	101 1111		av ailable)	months	Jan	Feb		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
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