E 1095-	asury	Emplo	•	o not attach to w.irs.gov/Form	1095C for instruct	tions and	your records. I the latest informat	ion.						20	22		
Internal Revenue Service Sold Service Sold Service Ser								rge Employer Member (Employer)				8 Employer identification number (EIN) 98-0154401					
1 Name of employee (	first name, middle in	nitial, last name)					Name of employer WIPRO LIMI	TED									
AMARENDRA 3 Street address (inclu	diag apartment no )						Street address (includ	ding room or suite no.)	2200					Contact telephon		r	
15510 RANCH ROAD 620 N APT 06204					2 TOWER ( intry and ZIP or foreign postal code 11 City or town			ENTER BLVD STE 2200				833-253-7717 <b>13</b> Country and ZIP or foreign postal code				code	
4 City or rown 5 State or province AUSTIN TX							EAST BRUNS	NJ Plan Start Month (enter 2-digit number):				0	08816				
Part II Employ					e's Age on Jan					Month		-					
	All 12 Months	Jan	Feb	Mar	Apr	M	ay June	July	Aug		Sept		Oct	Nov		Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	11	1H	1H	1H		1H		1E	1E		12	
15 Employee Required Contribution (see instructions)	\$	s	s	\$	s	\$	\$	s	\$	\$		<b>s</b> 17	70.00	<b>s</b> 170.0	0 <b>s</b> 1	170.	00
(6 Section 4980H Safe Harbor and Other Relief (enter code, f applicable)		2A	2A	2A	2A	2A	2A	2A	2A		2A		2C	20		2C	
17 ZIP Code For Privacy Act and Pa	annuadi Reductio	- Act Nation and		tions			at. No. 60705M							Fo	rm 1095	HC (20	22)
Form 1086-0 (2022	21														50	0320 Page 3	
Form 1095-C (2022		- If Employer (			check the box a	and ente	the information for	reach individual en	rolled in co	verace	including	the emi	njavee	x	50	0320 Page 3	
					, check the box a			r each individual en (e) DOB (If SSN or o			including	g the em	(e) Mon	nths of coverage		Page 3	
Part III Cover	red Individuals ·	(a) Name of	provided self-inst f covered individual( middle initial, last na	(s)	, check the box a		b) SSN or other TIN	r each individual en (c) DOB (rf SSN or o TIN is not available	ther (d) Co	vered	including	,	(e) Mon		Sept Oct	Page 3	Dec
	red Individuals ·	(a) Name of	f covered individual(	(s)	, check the box a			(c) DOB (if SSN or of	ther (d) Co	vered		,	(e) Mon	nths of coverage	Sepi Oct	Page 3	Dec X
Part III Cover	ed Individuals	(a) Name of First name, r	f covered individual(	(s)	, check the box a		b) SSN or other TIN	(c) DOB (if SSN or of	ther (d) Cor all 12 m	vered		,	(e) Mon	nths of coverage	Sept Oct	Page I t Nov X	Dec X X
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