

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) ***-**-3197		Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 98-0154401	
Name of employee (first name, middle initial, last name) MADHURI CHEELA				7 Name of employer WIPRO LIMITED			
Street address (including apartment no.) 600 ASYLUM AVENUE APT 1028				9 Street address (including room or suite no.) 2 TOWER CENTER BLVD STE 2200		10 Contact telephone number 833-253-7717	
City or town HARTFORD		5 State or province CT	6 Country and ZIP or foreign postal code 06105	11 City or town EAST BRUNSWICK		12 State or province NJ	13 Country and ZIP or foreign postal code 08816

Offer of Coverage (enter required code)	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		
Employee Required Contribution (see instructions)	\$	\$ 170.00	\$ 170.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00
Section 4980H Excess Harbor and Other Benefit (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
ZIP Code															

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

Cat. No. 60705M

Form 1095-C (2022)

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

