Form **1095-C**
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.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

600120

2022

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
ANBUMALAR SARAVANAN	XXX-XX-8952
3 Street address (including apartment no.)	
10675 SAPPHIRE TRAIL	
4 City or town	**5 State or province**	**6 Country and ZIP or foreign postal code**
DAVIDSON	NC	US 28036

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
TEKSYSTEMS, INC.	52-2010575
9 Street address (including room or suite no.)	**10 Contact telephone number**
7437 RACE ROAD	855-314-4222
11 City or town	**12 State or province**	**13 Country and ZIP or foreign postal code**
HANOVER	MD	US 21076

Part II Employee Offer of Coverage

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
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$ 446.71	$ 446.71	$ 446.71	$ 446.71	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2F	2B	2F	2F	2B	2A	2A	2A	2A	2A	2A	2A
17 ZIP Code													

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. ☐

	(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
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