7AV 0056 98412

000004279 J0301868
FAST SWITCH-GREAT LAKES LLC
17177 N LAUREL PARK DR., SUITE 2
LIVONIA, MI 48152

NAVANEETHA PURUSHOTHAMAN
43227 HERON DR
NOVI, MI 48375

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

600120

| 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
20**22** |

Part I   Employee | **Applicable Large Employer Member (Employer)**

1 Name of employee (first name, middle initial, last name) **NAVANEETHA PURUSHOTHAMAN**	2 Social security number (SSN) **XXX-XX-9104**	7 Name of employer **FAST SWITCH-GREAT LAKES LLC**	8 Employer identification number (EIN) **84-3717282**
3 Street address (including apartment no.) **43227 HERON DR**		9 Street address (including room or suite no.) **17177 N LAUREL PARK DR., SUITE 2**	10 Contact telephone number **269-599-2874**

4 City or town **NOVI**	5 State or province **MI**	6 Country and ZIP or foreign postal code **USA 48375**	11 City or town **LIVONIA**	12 State or province **MI**	13 Country and ZIP or foreign postal code **USA 48152**

Part II   Employee Offer of Coverage   **Employee's Age on January 1**   **Plan Start Month** (enter 2-digit number): **06**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	**1E**												
15 Employee Required Contribution (see instructions)	$	$ 235.48	$ 235.48	$ 235.48	$ 235.48	$ 235.48	$ 176.94	$ 176.94	$ 176.94	$ 176.94	$ 176.94	$ 176.94	$ 176.94
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2H	2H	2C	2C	2C	2H	2H	2H	2H

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
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.   Form **1095-C** (2022)