

# Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

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OMB No. 1545-2251 **600320**  
**2022**

<b>Part I</b> Employee		2 Social security number (SSN) ***-**-0814	Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 41-1991343
1 Name of employee (first name, middle initial, last name) JEEVANI NEELAM			7 Name of employer ST. JUDE MEDICAL, CARDIOLOGY DIVISION, INC.		
3 Street address (including apartment no.) 2055 BRADLEY STREET APT 205			9 Street address (including room or suite no.) 100 ABBOTT PARK ROAD		10 Contact telephone number 844-306-9222
4 City or town MAPLEWOOD	5 State or province MN	6 Country and ZIP or foreign postal code 55117	11 City or town ABBOTT PARK	12 State or province IL	13 Country and ZIP or foreign postal code 60064

14 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	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2C	2C	2C	2C	2C	2C	2C	2C
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. <input checked="" type="checkbox"/>					(e) Months of coverage											
18	(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	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
					JEEVANI NEELAM	***-**-0814							X	X	X	X
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