E 1095-C Department of the Treasi	n l	Employe	Employer-Provided Health Insuran Do not attach to your tax return. Keep fo Go to www.irs.gov/Form1095C for instructions an				r your records.				□ VOID □ CORRECTED			OMB No. 1545-2251 600120				
Part Employ					To the management	The state of the s	ge Employer Membe	er (Employer)							_			
1 Name of employee (fir LALITH AKH)	st name, middle in	hital, last name) PAVANI		2 Sox	cial security number (SS		rechnology Gr			-			8 Empl	oyer k	dentifica	ation nu	mber (EIN)	
3 Street address (including apartment no.) 8225 PERIDOT DR APT 104				A Series	9 Street address (incl	9 Street address (including room or suite no.) 245 SUMMER ST.								8 Employer Identification number (EIN) 20 - 8636067 10 Contact telephone number 8553144222				
4 City or town 5 State		5 State or province VA			6 Country and ZIP or foreign postal code US 22102		The second printed the second			ovince				13 Country and ZIP or foreign postal cod US 02210-1129				
Part II Employ	ree Offer of Co				s Age on January		Plan Start Month	00.0000	imberl:	01	100	-	US	02	210-	-112	9	
	All 12 Months	Jan	Feb	Mar	Apr	May June	July	Aug	Se			Oct	-		Nov	_	Dec	
14 Offer of Coverage		1E	1н	1н	1н	1н 1н	1H	1н	11	н		1н		1	н	11	1H	
(enter required code) 15 Employee Required				34.9	1		- 12,200			122	1					+		
Contribution (see Instructions)		. 119.17	. 20 1								s		s			s		
16 Section 4980H Safe								1			1		T	-1, 1	177			
Harbor and Other Relief (enter code, if applicable)		2C	2A	2A	2A	2A 2A	2A	2A	2	A		2A		2	A		2A	
17 ZIP Code						1 2 2 2			Fred .		1						14 3	
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Form 1095-C (2022)	and Individuals			7					D	3						PO	0320 Page 3	
		self-insured cover		ne box and ente	er the information for	each Individual enrolle	I (c) DOB (if SSN or other	(a) Covered	66.		Jan	_	Acriths o	f cover	rage		Page 3	
	loyer provided	self-insured cover (a) Name of covered irst name, middle init	f Individual(s) ial, last name		er the information for	(b) SSN or other TIN	d in coverage, includi (c) DOB (f SSN or othe TIN is not available)	ng the employ (d) Covered all 12 months	66.	еь Ма	r Apr	_	Months of	Cover uly A	rage Aug Se		0320 Page 3	
	loyer provided :	(a) Name of covered	f individual(s)		er the information for	each Individual enrolle (b) SSN or other TIN XXX-XX-8132	I (c) DOB (if SSN or other	(a) Covered	Jan F		r Apr	_	Aonths o	f cover	rage lug Se		Page 3	
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