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

0061548

Part I Employee

Field	Value
1 Name of employee (first name, middle initial, last name)	PREMCHAND RAVELLA
2 Social security number (SSN)	***-**-7326
3 Street address (including apartment no.)	120 COMMERCE WAY APT#531
4 City or town	WOBURN
5 State or province	MA
6 Country and ZIP or foreign postal code	01801

Applicable Large Employer Member (Employer)

Field	Value
7 Name of employer	ANALOG DEVICES INC
8 Employer identification number (EIN)	04-2348234
9 Street address (including room or suite no.)	ONE ANALOG WAY
10 Contact telephone number	888-234-7771
11 City or town	WILMINGTON
12 State or province	MA
13 Country and ZIP or foreign postal code	01887-2356

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)		1H	1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2C	2C	2C	2C	2C	2C
17 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. ☒

	(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
18	PREMCHAND RAVELLA	***-**-7326								X	X	X	X	X	X	X
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