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)	3 Street address (including apartment no.)	4 City or town	5 State or province	6 Country and ZIP or foreign postal code
SHIVANGI S KANITKAR	***-**-2361	1267 LAKESIDE DR APT 3086	SUNNYVALE	CA	94085

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)	9 Street address (including room or suite no.)	10 Contact telephone number	11 City or town	12 State or province	13 Country and ZIP or foreign postal code
NOKIA OF AMERICA CORPORATION	22-3408857	3201 OLYMPUS BLVD. ATTN: TAX DEPARTMENT SUITE 600-369	888-232-4111	DALLAS	TX	75019

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

	(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	SHIVANGI S KANITKAR	***-**-2361			X	X	X	X	X	X	X	X	X	X	X	X
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(e) Months of coverage: Jan–Dec columns above.