

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

2022

Part I Employee

2 Social security number (SSN)
***-**-5517

Applicable Large Employer Member (Employer)

8 Employer identification number (EIN)
62-1463468

1 Name of employee (first name, middle initial, last name)
PRADEEP BOMMIDI

7 Name of employer
ASURION INSURANCE SERVICES

3 Street address (including apartment no.)
42497 ROUGH ROCK COURT

9 Street address (including room or suite no.)
22894 PACIFIC BLVD

10 Contact telephone number
844-968-6278

4 City or town
CHANTILLY

5 State or province
VA

6 Country and ZIP or foreign postal code
20152

11 City or town
STERLING

12 State or province
VA

13 Country and ZIP or foreign postal code
20166

Part II Employee Offer of Coverage

Employee's Age on January 1

Plan Start Month (enter 2-digit number): 01

14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
			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													

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	(e) Months of coverage														
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
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