

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

Part I Employee

1 Name of employee (first name, middle initial, last name) SHRIMAT GOTHIVAREKAR		2 Social security number (SSN) XXX-XX-7173	7 Name of employer APPLE, INC.		8 Employer identification number (EIN) 94-2404110
3 Street address (including apartment no.) 37195 CREEKSIDE TERRACE APT 267		9 Street address (including room or suite no.) ONE APPLE PARK WAY		10 Contact telephone number 1-800-473-7411	
4 City or town FREMONT	5 State or province CA	6 Country and ZIP or foreign postal code US 94536	11 City or town CUPERTINO	12 State or province CA	13 Country and ZIP or foreign postal code US 95014

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	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$ 62.62	\$ 62.62	\$ 62.62	\$ 62.62	\$ 62.62	\$ 62.62	\$ 62.62	\$ 62.62
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.

	(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	
18	SHRIMAT GOTHIVAREKAR	XXX-XX-7173								X	X	X	X	X	X	X	X
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