Form 1095-C

VOID

Department of the Treasury Internal Revenue Service Part I Employee 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.

Applicable Large Employer Member (Employer) OMB No. 1545-2251 2022

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1 Name of employee (first name, middle initial, last name)	e (first name, n	niddle initial, last	name)	2 Social	2 Social security number (SSN)		7 Name of employer	oyer			8 Empl	8 Employer identification number (EIN)	n number (EIN)
Naga Abhiram		Bandred	ddy	***-**-7465	465		€Aptonet					20-1968146	46
3 Street address (including apartment no.)	cluding apartm	ent no.)					9 Street address (including room or suite no.)	(including room	or suite no.)		10 Conta	10 Contact telephone number	Imber
3805 lochmar trail	rail						1255 Canton St.,	St., Bldg B			, n	(610) 955-4994	1994
4 City or town	5	5 State or province	Ce	6 Country	6 Country and ZIP or foreign postal code	_	11 City or town		12 State or province	vince	13 Count	13 Country and ZIP or foreign postal code	eign postal code
Cumming	0	GA		30040			Roswell		GA		30075		
Part II Employee Offer of Coverage	loyee Offe	r of Covera	ge		Employee':	s Age on J	Employee's Age on January 1 26		Plan Start	Plan Start Month (enter 2-digit number): 11	er 2-digit nu	mber): 11	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		Ĥ	1H	Î	主	m	Ê	m	m	Ê	È	Ê	主
15 Employee Required Contribution (see instructions)	07	₩	₩	↔	↔	\$ 175.00	\$ 175.00	\$ 175.00	\$ 175.00	\$ 175.00	\$ 175.00	\$ 175.00	↔
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2H	2H	24	2Н	2H	2Н	L	2B
17 ZIP Code													
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	ıd Paperwor	k Reduction /	\ct Notice, se	e separate in	structions.			Cat. N	Cat. No. 60705M			Form 1	Form 1095-C (2022)

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												Naga	(a) Name o First name, r	If Emp
			a <sup>r</sup>			2						AbhiraBandreddy	(a) Name of covered individual(s) First name, middle initial, last name	If Employer provided se
												ndreddy	ual(s) name	d self-insured
		- h		* 8 ]					, a	் சிக		***-**-7465	(b) SSN or other TIN	If Employer provided self-insured coverage, check the box and enter the information for each individual
													(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	e box and enter the
													(d) Covered all 12 months	informatic
													Jan	n for e
													Feb	ach ind
													Mar	ividual
													Apr	enrollec
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													Months of	erage, i
													(e) Months of coverage  / June July /	ncludin
													Aug	g the e
												. 🗆	Sept	ual enrolled in coverage, including the employee.
													Oct	Ф
												×	Nov	
			П		П						П	$\overline{\times}$	Dec	