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)
RAMA KRISHNA SUMANTH | | GUMMADAPU	XXX-XX-6331
3 Street address (including apartment no.)	
210 WALL ST APT 807	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
SEATTLE	WA	US 98121

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
AMAZON.COM SERVICES LLC	82-0544687
9 Street address (including room or suite no.)	10 Contact telephone number
PO BOX 81226	866-644-2696
11 City or town	12 State or province	13 Country and ZIP or foreign postal code
SEATTLE	WA	US 98108

Part II Employee Offer of Coverage

Employee's Age on January 1:

Plan Start Month (enter 2-digit number): 04

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 33.00	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	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
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