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## Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

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Internal Revenue Service	6	o to www.irs.gov/Form	1095C for instructions	Go to www.irs.gov/Form1095C for instructions and the latest information.			COXXECTED		7707	
Part I Employee				Applicable Large Employer Member (Employer)	ployer Membe	r (Employer)				
1 Name of employee (first name, middle initial, last name)	middle initial, last name)	2.50	2 Social security number (SSN)	7				B Cooks	or identification author (F	
HARSHITHA	BOLLINENI	×	XXX-XX-8606		ORATION			8 Employ	3 Employer identification number (EIN) 94-3207296	N.
3 Street address (including apartment no.)	nent no.)			9 Climat addison (inclinding	0.01.101			-16	3201296	
4734 SOUTH PLUTO	3			ASS NOPTH STATE HTG:	om or suite no.)	1		10 Conta	10 Contact telephone number	
4 City or town	5 State or province	a Country	and 7ID as families as dell	OCCUPATION OF THE HIGHWAY TOT	WIE HIGHW	AY 161		855	8553144222	
MESA	AZ	US 85212	US 85212	T P17 T NO	-	12 State or province		13 Count	try and ZIP or foreign posta	8
Sala Employee Offi	or of Coverage			TVATING		X		SU	US 75039	
	or or occurate	Employee	Employee's Age on January 1:		Plan Start Month (enter 2-digit number): 01	(enter 2-digit nur	nber): 01			
All 12	All 12 Months Jan	Feb Mar	Agr	May						
			•	way June	July	Pug	Sept	Og.	Nov	5

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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form 1095-C (2022)

14 Offer of Coverage (enter required code) 15 Employee Required Contribution (see instructions)

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136.00

16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

20

17 ZIP Code

Cat. No. 60705M

Form 1095-C (2022)

28 28 27 27 28 29 29	21 22 22 24 24 24 24 24 24 24 24 24 24 24	Part IIII Covered Individuals (i) Name of First name, m  18 HARSHITHA
		Part III Covered Individuals  Covered Individual enrolled in coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.  (a) Name of covered individual enrolled in coverage, including the employee.  (b) SSN or other TIN (c) DOB (if SSN or other TIN is not available) all 12 months Jar
		to reach individual enrolled in coverage, including the employee.  (b) SSN or other TIN (c) DOB (r SSN or other (d) Covered TIN is not available)  XXXX-XX-8606  XXXX-XX-8606
		uding the employee.  Note to Covered all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec