For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	17 ZIP Code	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	15 Employee Required Contribution (see instructions)	14 Offer of Coverage (enter required code)		Part II Employee Offer of Coverage	Haymarket	4 City or town	6609 Bartrams Forest Ln	3 Street address fin	1 Name of employee (first name, middle initial, last name)	Part I Employee	Department of the Treasury Internal Revenue Service	1095-C
d Paperwork		2C	€	1A	All 12 Months	oyee Offer	VA	5	Forest Ln		e (first name, mid	oyee	ice	<u>.</u>
Reduction A					Jan	of Covera	Α .	5 State or province	7	TACTIONOTION	ddle initial, last r			Empl
ct Notice, se			₩		Feb	ge		Φ		orida	name)		Go to www.	Employer-Provided Health Insurance Offer and Coverage
e separate inst			₩		Mar	Er	20169 USA	a Country an		,	2 Social sec		irs.gov/Form10	vided He
ructions.			(0		Apr	Employee's Age on January 1	SA	Country and ZIP or foreign postal code			2 Social security Fluitiber (SSR)	in pumber (s	Go to www.irs.gov/Form1095C for instructions and the latest information	alth Insi
					May	Age on Ja		_	ם ס			7	uctions and	n. Keep for
			₩		June	nuary 1	Culpeper	11 City or town	P.O. Box 2005	Charles II.	S W E T	Ap	the latest inf	Offer an
Cat. No			Ө		July				(including room)	7	1	Applicable I	ormation	d Covera
Cat. No. 60705M			69	Aug	rian Stair		12 State or province		or suite no.)		ge Employ		O O	3
			₩	1	Sept	NA Court Month (enter 2-digit number):	псе				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	le la	CORRECTED	Void
			0,		Oct	er 2-digit nu	22701	13 Coun	OF CORR		8 Empl	(Employe	ECTED	
Form			₩		Nov	mber):	22701 USA	try and ZIP or fo	7033656090	o de la constante de la consta	loyer identification lite	3		OMB No. 1545-2251
Form 1095-C (2023)			()		Dec	91		13 Country and ZIP or foreign postal code	3090	imber	8 Employer identification intribet (First)			1545-2251

Form 1095-C (2023) 600320 Page **3**

0	6	86	7	8	67	4	ಟ	R	13	180	19	8		Ţ
										Vishruth	Bhargav	Shravya	(a) N	Part III (
										3	<	σ,	(a) Name of covered individual(s) First name, middle initial, last name	Covered Individuals If Employer provided se
										Z	ZD	Z)	vered indivile initial, la	I Indivic
										Rajammagari	Rajammagari	Rachakonda	idual(s) st name	luals led self-insure
												xxx-xx-4677	(b) SSN or other TIN	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enterties.
										10/30/2022			(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	he box and enter th
										\boxtimes	\boxtimes	\times	(d) Covered all 12 months	e informati
													Jan	on for e
													Feb	ach ind
													Mar	ividual
													An Irolled in	
												May Say	(e) Mo	
													(e) Months of coverage	ing
													f coverage	cluding
													Aug	the er
													Sept	including the employee.
													Oct	× io
													Nov	
													Dec	