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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 OMB No. 1545-2251 CORRECTED

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Part I Emp	loyee					Applicable Large Employer Member (Employer)										
1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)								loyer	8 Er	8 Employer identification number (EIN)						
SAI KIRAN BOJEDLA					746-27-2977					81-4143431						
3 Street address (	including apartr	ment no.)					9 Street addres	s (including roor	<b>10</b> Co	10 Contact telephone number						
1139 MORN	ING GLOR	Y DR					4105 US H	<b>IGHWAY</b> 1	(	(732) 642-3423						
4 City or town 5 State or province					6 Country and ZIP or foreign postal code				12 State or pro	vince	<b>13</b> Co	13 Country and ZIP or foreign postal code				
MONROE TWP NJ			0883	1		MONMOUT	H JUNCTIO	N	NJ	088	08852					
Part II Emp	loyee Offe	er of Covera	age		Employee's	Age on J	anuary 1		Plan Start	t <b>Month</b> (en	ter 2-digit r	number): <b>04</b>				
	All 12 Months	s Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)	1E															
15 Employee Required Contribution (see instructions)	\$	\$ 136.30	\$ 136.30	\$ 136.30	\$ 137.57	\$ 137.57	\$ 137.57	\$ 137.57	\$ 137.57	\$ 137.57	\$ 137.5	7 \$ 137.57	\$ <b>137.57</b>			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C															
17 ZIP Code			Act Notice, see										<b>095-C</b> (202			

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

Form **1095-C** (2023)

			f-insured coverage, c					ach inc	lividual	enrolle					employe	e. <b>X</b>		
	(a) Name of o	covered individual(s) ddle initial, last name	(b) SSN or ot	her TIN	(c) DOB (if SSN or other TIN is not available)	r (d) Covered all 12 months	(e) Months of coverage   Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec											
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