

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

Part I Employee		2 Social security number (SSN) ***-**-9792	Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 26-0116361
1 Name of employee (first name, middle initial, last name) MOHAN SIVA KRIS KONAKANCHI			7 Name of employer MORGAN STANLEY SERVICES GROUP INC,		
3 Street address (including apartment no.) 1669 STOWERS TRAIL			9 Street address (including room or suite no.) 750 7TH AVE 6TH FLOOR - PAYROLL		10 Contact telephone number 877-674-7411
4 City or town HASLET	5 State or province TX	6 Country and ZIP or foreign postal code 76052	11 City or town NEW YORK	12 State or province NY	13 Country and ZIP or foreign postal code 10019-6800

14 Offer of Coverage (enter required code)	Employee's Age on January 1												Plan Start Month (enter 2-digit number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
15 Employee Required Contribution (see instructions)	\$	\$ 156.00	\$ 156.00	\$ 156.00	\$ 156.00	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code															

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 1095-C (2023)

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. <input checked="" type="checkbox"/>															
(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
18 MOHAN SIVA KRIS KONAKANCHI	***-**-9792			X	X	X	X								
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