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Internal Revenue Service		OO TO WAY	ATT SOLVE OF	Go to www.rs.govr-orm resect for instructions and the latest information.	structions an	d the latest in	ormation.					
Part Employee		7				Αþ	olicable La	rge Employ	Applicable Large Employer Member (Employer)	r (Employe	3	
<ol> <li>Name of employee (first name, middle initial, last name)</li> </ol>	middle initial, last	name)	2 Social	2 Social security number (SSN)		7 Name of employer	yer			8 Emp	8 Employer identification number (EIN)	number (EIN)
RAJENDRA	P  SADINENI	2				MEDLINE INDUSTRIES,	IDUSTRIES	ș, FP			36-25	
3 Street address (including apartment no.)	(nent no.)					9 Street address (including room or	(including room	or suite no.)		10 Cont	10 Contact telephone number	mber
830 PACIFIC AVE APT C	C					3 LAKES DRIVE	ANE.				(847) 949-2065	065
4 City or town	5 State or province	*	6 Country	6 Country and ZIP or foreign postal code 11 City or town	postal oode	1 City or town		12 State or province	vince	13 Count	13 Country and ZIP or foreign postal code	in postal code
HOFFMAN ESTATES		_		60169-4707	7	NORTHFIELD	.D		7		60093	
Part II Employee Offer of Coverage	fer of Covera	ge		Employee's Age on January 1	: Age on J	anuary 1		Plan Start	lan Start Month (enter 2-digit number): 01	er 2-digit nu	mber): 01	
All 12 Months	s Jan	Feb	Mar	Apr	Мау	June	July	QuA	Sopt	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H	£	ź	1H	1E	1E	Ħ	Æ	1E	ñ	íñ	ñ
15 Employee Required Contribution (see instructions)	S	S	G	G	\$ 108.41 S	s 108.41 \$	\$ 108.41 \$	1	\$ 108.41	\$ 108.41	108.41 \$ 108.41 \$ 108.41 \$ 108.41	\$ 108.41
16 Section 4980H Sale Harbor and Other Relief (enter code, if applicable)	2A	2A	20	2D	20	20	20	20	20	20	20	20
17 ZIP Code												
REMINI Covered Individuals  If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	vided self-insur	ed coverage	e check the	box and ente	r the informa	ation for each	hdividual e	nrolled in co	verage, inclu	ding the em	plovee. X	A

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

Chowdary RAJENDRA (a) Name of covered individual(s) First name, middle initial, last name Sadineni SADINENI Kongara (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered
TIN is not available) all 12 months dan Feb Mar ₽ × × × May June  $\times$  $\times$ × (e) Months of coverage × × × July × ×  $\times$ BnV ×  $\boxtimes$  $\times$ Sept  $\times$ ×  $\times$ š × × × Nov × ×  $\times$ Dec ×  $\times$ ×

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

Form 1095-C 2023

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