Form **1095-C**
Department of the Treasury
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
☐ CORRECTED

OMB No. 1545-2251 600120

2023

0004138

Part I Employee

1 Name of employee (first name, middle initial, last name)	LATHA CHANDRAN
2 Social security number (SSN)	***-**-2230
3 Street address (including apartment no.)	414 210TH ST SE
4 City or town	BOTHELL
5 State or province	WA
6 Country and ZIP or foreign postal code	98021

Applicable Large Employer Member (Employer)

7 Name of employer	T-MOBILE USA INC
8 Employer identification number (EIN)	91-1983600
9 Street address (including room or suite no.)	12920 SE 38TH STREET
10 Contact telephone number	855-866-2367
11 City or town	BELLEVUE
12 State or province	WA
13 Country and ZIP or foreign postal code	98006

Part II Employee Offer of Coverage

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
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1E	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$ 78.00	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2G	2G	2G	2G	2G	2G	2G	2G	2G	2G	2B	2A
17 ZIP Code													

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

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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. ☐

	(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
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