Form 1095-C

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

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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 Empl	DUBLIN	4 City or town	3 Street address (including spartment no.) 5704 Briardale Ct Apt B	Bharath Kunjal	1 Name of employee (first name, middle initial, last name)	Part I Employee	Internal Revenue Service
	20	s 132.93 s	ź.	All 12 Months	Employee Offer of Coverage	P	5 5	uding apartment opt B		(first name, mid-	loyee	ervice
	9			Jan	of Coverage		5 State or province	no.)		dle initial, last na		Go
		co.		Feb						me)		Go to www.irs.gov/Form1095C for instructions and the latest information.
		5		Mar		US 43016	6 Country and		XXX-XX-1379	2 Social secu		Irs.gov/Form1095C for instructions and the latest infon
		5		Apr	Employee's		6 Country and ZIP or foreign postal code		9	2 Social security number (SSN)		c for instruct
		S		May	Employee's Age on January 1	1	_	- 0	X			ions and the
		so.		June	inuary 1	Tampa	11 City or town	Street address (150 Assembly	Kforce inc	7 Name of employer		latest informa
		en.		July				9 Street address (including room or suite no.) 1150 Assembly Dr Ste 500 Attn Benefits Department		et .	Applica	ition.
		50		Aug	Plan Start	F	12 State or province	n Benefits Dep			Applicable Large Employer	1
		so.		Sept	Plan Start Month (enter 2-digit number):			artment				
		4		Oct	r 2-digit nun	us 33607	13 Counti	10 Contact teld 8668075074	59-3264661	8 Employ	Member (Employer)	
		s)		Nov	nber): 01	77	13 Country and ZIP or foreign postal code	10 Contact telephone number 8668075074	861	8 Employer identification number (EIN)	loyer)	2023
		w		Dec			reign postal cor	nber		number (EIN)		3

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

Form 1095-C (2023)

Page 3

Form 1095-C (2023)

Part III Covered Individuals

-	29	28	27	26	25	24	23	22	21	20	19	=	1		
					· ·		3 Sinchana Kunjal	2 Sinchana Kunjal	1 Sannidhi Kunjal	0 Sannidhi Kunjal	9 Pallavi Kudethur	18 Bharath Kunjal	First name, middle initial, last name	(a) Name of covered individua(s)	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.
							XXX-XX-4635	XXX-XX-5087	XXX-XX-8766		XXX-XX-1176	XXX-XX-1379		(b) SSN or other TIN	box and enter the information
										2021-05-30			(c) DOB (if SSN or other TIN is not available)		on for each individual en
								×		×		×	all 12 months	(d) Covered	rolled in cover
							×		×		×		Jan		age, in
-							×		×		×		Feb		cludin
							×		×		×		Mar		g the e
	1000						×		×		×		Apr		mploy
1							×		×		×		May	0	ee.
		ug l											June	Months	
													July	(e) Months of Coverage	×
								1					Aug	erage	
			4.4										Sept		
								1					8		
-								10					Nov		
	- In												Dec		

Form 1095-C (2023)