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

## Part I Employee

| 1 Name of employee (first name, middle initial, last name) | 2 Social security number (SSN) |
|---|---|
| RAKESH KATKURI | XXX-XX-4070 |
| 3 Street address (including apartment no.) | |
| 173 AUTUMNWOOD ROAD | |
| 4 City or town | 5 State or province |
| TROUTMAN | NC |
| 6 Country and ZIP or foreign postal code | |
| US 28166 | |

## Applicable Large Employer Member (Employer)

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| THE KROGER CO. | 31-0345740 |
| 9 Street address (including room or suite no.) | 10 Contact telephone number |
| 1014 VINE ST | 1-800-952-8889 |
| 11 City or town | 12 State or province |
| CINCINNATI | OH |
| 13 Country and ZIP or foreign postal code | |
| US 45202 | |

## 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) | | 1H | 1H | 1H | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E |
| 15 Employee Required Contribution (see instructions) | $ | $ | $ | $ | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 | $ 36.50 |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2A | 2A | 2D | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C |
| 17 ZIP Code | | | | | | | | | | | | | |

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

Cat. No. 60705M

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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 |
| 18 | RAKESH KATKURI | XXX-XX-4070 | | | | | | X | X | X | X | X | X | X | X | X |
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