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 | **Applicable Large Employer Member (Employer)**

Field	Value
1 Name of employee (first name, middle initial, last name)	PRADEEP BOMMIDI
2 Social security number (SSN)	***-**-5517
3 Street address (including apartment no.)	42497 ROUGH ROCK COURT
4 City or town	CHANTILLY
5 State or province	VA
6 Country and ZIP or foreign postal code	20152
7 Name of employer	ASURION INSURANCE SERVICES
8 Employer identification number (EIN)	62-1463468
9 Street address (including room or suite no.)	22894 PACIFIC BLVD
10 Contact telephone number	844-968-6278
11 City or town	STERLING
12 State or province	VA
13 Country and ZIP or foreign postal code	20166

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	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	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 Form **1095-C** (2023)

Form 1095-C (2023) 600320

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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