

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.

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Part I Employee		2 Social security number (SSN) ***-**-1905		Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 98-0154401	
1 Name of employee (first name, middle initial, last name) SARAT KUMAR SAHOO				7 Name of employer WIPRO LIMITED			
3 Street address (including apartment no.) 13145 N HIGHWAY 183 APT 925				9 Street address (including room or suite no.) 2 TOWER CENTER BLVD STE 2200		10 Contact telephone number 833-253-7717	
4 City or town AUSTIN		5 State or province TX	6 Country and ZIP or foreign postal code 78750	11 City or town EAST BRUNSWICK		12 State or province NJ	13 Country and ZIP or foreign postal code 08816

14 Offer of Coverage (enter required code)	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		
15 Employee Required Contribution (see instructions)	\$	\$ 170.00	\$ 170.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00	\$ 145.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code															

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	SARAT KUMAR SAHOO	***-**-1905			X	X	X	X	X	X	X	X	X	X	X	X	X
19	SATABDEE DAS	***-**-9755			X	X	X	X	X	X	X	X	X	X	X	X	X
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