

**Employer-Provided Health Insurance Offer and Coverage**

Do not attach to your tax return. Keep for your records.  
Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

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 CORRECTED

OMB No. 1545-2251 **600120**  
**2023**

<b>Part I</b> Employee		2 Social security number (SSN) ***-**-4443	Applicable Large Employer Member (Employer)		8 Employer identification number (EIN) 54-1966544
1 Name of employee (first name, middle initial, last name) PREETHI PANDURANGAN		7 Name of employer FOLIO FINANCIAL, INC (4843)			
3 Street address (including apartment no.) 8250 WESTPARK DR 322		9 Street address (including room or suite no.) C/O GOLDMAN SACHS 200 WEST STREET		10 Contact telephone number 877-454-7426	
4 City or town MC LEAN	5 State or province VA	6 Country and ZIP or foreign postal code 22102	11 City or town NEW YORK	12 State or province NY	13 Country and ZIP or foreign postal code 10282

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	
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													

**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 PREETHI PANDURANGAN	***-**-4443			X	X	X	X	X	X	X	X	X	X	X	X	X
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