

# 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.

VOID  
 CORRECTED

**2023**

8 Employer identification number (EIN)  
20-1543776

<b>Part I Employee</b>		2 Social security number (SSN) ***-**-5605	<b>Applicable Large Employer Member (Employer)</b>	
1 Name of employee (first name, middle initial, last name) AYUSH RAJ		7 Name of employer DISCOVER PRODUCTS INC		10 Contact telephone number 844-337-6947
3 Street address (including apartment no.) 99 VISTA MONTANA, APT 1527		9 Street address (including room or suite no.) 2500 LAKE COOK ROAD		13 Country and ZIP or foreign postal code 60015
4 City or town SAN JOSE	5 State or province CA	6 Country and ZIP or foreign postal code 95134	11 City or town RIVERWOODS	12 State or province IL

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)	\$	\$	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17	\$ 127.17
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2C	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)

**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 AYUSH RAJ	***-**-5605			X	X	X	X	X	X	X	X	X	X	X	X
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