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)
CHINMAYEE GULLAPALLI	***-***-5160
3 Street address (including apartment no.)	
4017 AGATHA CT	
4 City or town	5 State or province
AUBREY	TX
6 Country and ZIP or foreign postal code	
76227	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
NORDSTROM, INC.	91-0515058
9 Street address (including room or suite no.)	10 Contact telephone number
1600 7TH AVE., SUITE 2500	844-487-5595
11 City or town	12 State or province
SEATTLE	WA
	13 Country and ZIP or foreign postal code
	98101

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number): 03

	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													

Employee's Age on January 1

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
18	CHINMAYEE GULLAPALLI	***-***-5160			☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
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