

LUCID USA INC
7373 Gateway Boulevard
Newark CA 94560



093165
Pradeep Yellamoni
40045 W James Ln
Maricopa AZ 85138

1 OF 1

SECRET SYSTEMS SOLUTIONS

Form 1095-C

Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095-C for instructions and the latest information.

VOID
 CORRECTED

OMB No. 1545-0047 600320
2023
Employer identification number (EIN)
26-1618465

| | | | | | |
|---|---|--|--|----------------------------|--|
| Part I Employee | 2 Social security number (SSN) ***-**-1979 | Applicable Large Employer Member (Employer) | 8 Employer identification number (EIN) 26-1618465 | | |
| 1 Name of employee (first name, middle initial, last name) Pradeep Yellamoni | | 7 Name of employer LUCID USA INC | 19 Contact telephone number 510-255-2487 | | |
| 3 Street address (including apartment no.) 40045 W James Ln | | 9 Street address (including room or suite no.) 7373 Gateway Boulevard | | | |
| 4 City or town Maricopa | 5 State or province AZ | 10 Country and ZIP or foreign postal code US 85138 | 11 City or town Newark | 12 State or province CA | 13 Country and ZIP or foreign postal code 94560 |

| 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) 1E | | | | | | | | | | | | | | | | | |
| 15 Employee Required Contribution (see instructions) \$ 0.00 | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 16 Section 4850H Safe Harbor and Other Relief (enter code, if applicable) 2C | | | | | | | | | | | | | | | | | |
| 17 ZIP Code | | | | | | | | | | | | | | | | | |

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 1095-C (2023)

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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 (do not include title, maiden name, or suffix) | (b) SSN or other TIN ***-**-1979 | (c) DOB (if SSN or other TIN is not available) | (d) Covered as of 12 months <input checked="" type="checkbox"/> | (e) Months of coverage | | | | | | | | | | | | | |
|---|-------------------------------------|--|--|------------------------|-----|-----|-----|-----|------|------|-----|------|-----|-----|-----|--|--|
| | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | | |
| 18 Pradeep Yellamoni | | | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
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