

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. 1545-2281

2023

600120

Part I Employee

Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name) LARAAB QURESHI		2 Social security number (SSN) XXX-XX-6521	7 Name of employer TD BANK NA		8 Employer identification number (EIN) 01-0137770
3 Street address (including apartment no.) 16012 PEMBERLY WAY			9 Street address (including room or suite no.) 2035 LIMESTONE ROAD		10 Contact telephone number 888-275-9759
4 City or town HASLET	5 State or province TX	6 Country and ZIP or foreign postal code US 76052	11 City or town WILMINGTON	12 State or province DE	13 Country and ZIP or foreign postal code US 19808

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) \$ 44.71													
16 Section 4980H 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

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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(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	LARAAB QURESHI	XXX-XX-6521		<input checked="" type="checkbox"/>														
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