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) SHILPA SONI	2 Social security number (SSN) XXX-XX-4911
3 Street address (including apartment no.) 418 WHITREE LANE	

4 City or town CHESTERFIELD	5 State or province MO	6 Country and ZIP or foreign postal code US 63017

Applicable Large Employer Member (Employer)

7 Name of employer
PFIZER INC

9 Street address (including room or suite no.)
66 HUDSON BOULEVARD EAST

11 City or town NEW YORK	12 State or province NY

8 Employer identification number (EIN)
13-5315170

10 Contact telephone number
8553144222

13 Country and ZIP or foreign postal code
US 10001

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)	$ 71.00	$	$	$	$	$	$	$	$	$	$	$	$
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

Form **1095-C** (2023)

Form 1095-C (2023)

600320
Page 3

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	SHILPA	SONI	XXX-XX-4911		✗												
19	NEEVA	S MOHAPATRA	XXX-XX-8423		✗												
20	NRUSINGH	P MOHAPATRA	XXX-XX-7538		✗												
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