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

Field	Value
1 Name of employee (first name, middle initial, last name)	ANKITHA | CHANDRAHASAN
2 Social security number (SSN)	XXX-XX-8304
3 Street address (including apartment no.)	3312 170TH PL SE
4 City or town	BOTHELL
5 State or province	WA
6 Country and ZIP or foreign postal code	US 98012

Applicable Large Employer Member (Employer)

Field	Value
7 Name of employer	AMAZON.COM SERVICES LLC
8 Employer identification number (EIN)	82-0544687
9 Street address (including room or suite no.)	PO BOX 81207
10 Contact telephone number	(206) 266-1000
11 City or town	SEATTLE
12 State or province	WA
13 Country and ZIP or foreign postal code	US 98108-1207

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)	1A												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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
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