

Part I Employee 2 Social security number (SSN) ***-**-4977 **Applicable Large Employer Member (Employer)** 8 Employer identification number (EIN) 72-0542904

1 Name of employee (first name, middle initial, last name) MANIVIGNESH KUPPUSAMY 7 Name of employer ACCENTURE LLP
 3 Street address (including apartment no.) 3410 SURREY HEIGHTS DRIVE APT 301 9 Street address (including room or suite no.) 6415 BABCOCK ROAD SUITE 100 10 Contact telephone number 877-332-2242
 4 City or town EAGAN 5 State or province MN 6 Country and ZIP or foreign postal code 55122 11 City or town SAN ANTONIO 12 State or province TX 13 Country and ZIP or foreign postal code 78249

Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01

14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2C	2C	2C	2C	2C
17 ZIP Code													

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

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 MANIVIGNESH KUPPUSAMY	***-**-4977											X	X	X	X	X	X
19 KOMATHI JAYAPAL		1990-10-02															X
20 NILAZHINI KUPPUSAMY		2021-05-26															X
21																	
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