10C 0070 B8227 000000174

000018088 J0528815

DENKEN SOLUTIONS INC
9170 IRVINE CENTER DRIVE
IRVINE, CA 92618

10CPNA95CPH0000043597A405A979

018102 RO9MWB01 10C 0070 B8227 000000174
SIMHACHALAM N LEKKALA
9100 INDEPENDENCE PARKWAY
APT#2601
PLANO, TX 75025

S 018102 RO9MWB01 018102E

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

600120

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

2023

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
SIMHACHALAM N LEKKALA	XXX-XX-7037
3 Street address (including apartment no.)	
9100 INDEPENDENCE PARKWAY	
4 City or town	**5 State or province**
PLANO	TX
6 Country and ZIP or foreign postal code	
USA 75025	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
DENKEN SOLUTIONS INC	27-3050679
9 Street address (including room or suite no.)	**10 Contact telephone number**
9170 IRVINE CENTER DRIVE	949-688-3995
11 City or town	**12 State or province**
IRVINE	CA
13 Country and ZIP or foreign postal code	
USA 92618	

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)	$ 174.62	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
17 ZIP Code													

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐