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

2 Social security number (SSN)	Applicable Large Employer Member (Employer)	8 Employer identification number (EIN)
***-**-5469		27-3572632

1 Name of employee (first name, middle initial, last name)	7 Name of employer
MANAV KOTAK	DFS CORPORATE SERVICES LLC

3 Street address (including apartment no.)	9 Street address (including room or suite no.)	10 Contact telephone number
810 W PANORAMA DR UNIT 309	2500 LAKE COOK ROAD	844-337-6947

4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town	12 State or province	13 Country and ZIP or foreign postal code
PALATINE	IL	60067	RIVERWOODS	IL	60015

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)		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	2A	2D	2G	2G	2G	2G
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
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