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) |
|---|---|---|
| ***-**-8827 | | 94-1687665 |

| 1 Name of employee (first name, middle initial, last name) | 7 Name of employer |
|---|---|
| ARUNPRABHU THIRUMALAISAMY VELLADURAI | BANK OF AMERICA NATIONAL ASSOCIATION |

| 3 Street address (including apartment no.) | 9 Street address (including room or suite no.) | 10 Contact telephone number |
|---|---|---|
| 5665 LIGHTFOOT LN | 401 NORTH TRYON ST SUITE 170 | 800-556-6044 |

| 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 |
|---|---|---|---|---|---|
| FRISCO | TX | 75036 | CHARLOTTE | NC | 28202 |

## 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 | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E |
| 15 Employee Required Contribution (see instructions) | $ | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 | $ 162.58 |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 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 | ARUNPRABHU THIRUMALAISAMY VELLADURAI | ***-**-8827 | | | X | X | X | X | X | X | X | X | X | X | X | X |
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