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instructions		Service of Major Till And Service of Service		And Therhold (Sense)	A COST OF CHAN	01/25/1983			(c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	10	INDIANAPOLIS	20 City or town			ructions)	13 City or town	ACTION OF SELECTION	Information About Certain Employer-Sponsored Coverage (see instructions)	1s for codes):	KENT	S City or town	1			Go to www.irs.gov/Form1095B for instructions and the latence of	nealth Coverage	U^, IAL >
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

036653 RO9CV801 CP1 0075 C315A 000000138 AMITHA NEERATI 60 WANDA COURT KENT, OH 44240

Form 1095-C(2023)

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

P00750 VOID OMB No. 1545-2251 Form 1095-C Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. CORRECTED 23 Department of the Treasury Internal Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I Employee 2 Social security number (5SN) 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) SHAKLEE CORPORATION 94-3389365 XXX-XX-0727 AMITHA NEERATI 10 Contact telephone number 3 Street address (including apartment no.) 9 Street address including room or suite no.) 925-924-3067 6920 KOLL CTR PKWY 211 SUITE 211 60 WANDA COURT 6 Country and ZIP or foreign postal code 13 Country and ZIP or foreign postal code 4 City or town 5 State or province 11 City or town 12 State or province USA 44240 **PLEASANTON** CA USA 94566 KENT OH Plan Start Month (enter 2-digit number): 04 Part II Employee Offer of Coverage Employee's Age on January 1 All 12 Months Feb Mar May July Sept Oct Nov Dec Jan Apr Aug 14 Offer of Coverage (enter required code) 1H 1H 1E 1E 1E 1E 1E 1E 1H 1H 1H 1H 15 Employee Required Contribution (see 130.00\$ 130.00\$ 130.00\$ 130.00\$ 130.00\$ 130.00 instructions) 16 Section 4980H 2C 2C 2C 2C 2C 2C 20 2A 2A 2A 2A 2D code, if applicable) 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. (e) Months of coverage (a) Name of covered individual(s) First name, middle initial, last name (b) SSN or other TIN (d) DOB (if SSN or other TIN is not available) all 12 months Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept 18 19 20 21 22

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