

Form 1095-C
Department of the Treasury

Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage | VOID

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

□ CORRECTED G

OMB No. 1545-2251

2023

Part I Em	rt I Employee							Applicable Large Employer Member (Employer)											
Name of employee-First name, middle initial, last name SHARATH						l security numbe X-XX-9893	r (SSN)	7 Name of em BLUE CR		8 E	8 Employer identification number (EIN) 63-0103830								
									ss (including roo RCHASE PK	A CONTRACTOR OF THE PARTY OF TH			10 Contact telephone number 205-220-2555						
4 City or town FUQUAY VARINA NC				6 Country and ZIP or foreign postal code 27526-2283			11 City or town BIRMING		12 State or p	province	the first of the second second second	13 Country and ZIP or foreign postal code 35244							
Part II Emp	loyee Offe	r of Cover	age	Emp	oloyee'	s Age on J	anuary 1:	33 P	lan Start M	lonth (Enter	2-digit num	nber): 01	Die ests to areg or between won	E selfbhr ni cholaidean					
14 Offer of Coverage (enter required code)	All 12 Months	. Jan	Feb		Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
		1H	1E	1E		1E	1E	1E	1E	1E	1E	1E	1E	1E					
15 Employee Required Contribution (see instructions)	\$	\$	\$ 112.13	\$	112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13	\$ 112.13					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	toy of bench on 91°, some services with the services	2D	2C	2C		2C	2C	2C	2C	2C	2C	2C	2C	2C					
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For Privacy Act a	nd Paperworl	k Reduction A	Act Notice, see	separ	ate instru	uctions.			Cat. N	o. 60705M	Print Date: 01/	19/2024	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. X

(a) Name of covered individual(s)			(b) SSN or other TIN	c) DOB (If SSN or other TIN is not available)	d) Covered all 12 months		(e) Months of coverage										
First name, middle initial, last name		Jan				Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
18 SHARATH	K	ALLAM	XXX-XX-9893	10/27/1989		ez pay Vijira	X	X	X	X	X	Х	Х	X	X	X	Х
19 JOSEPH	R	KOM- MAREDDY	XXX-XX-8831	04/01/1996		Adana Appre	X	X	X	X	X	X	X	X	X	X	X
20 ZEKE	A	ALLAM	XXX-XX-7295	12/22/2022			X	X	X	X	X	X	X	X	Х	Х	X
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