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

600120
OMB No. 1545-2251
2023

Part I Employee				**Applicable Large Employer Member (Employer)**		
1 Name of employee (first name, middle initial, last name) VISHAKHA LADDHA			2 Social security number (SSN) XXX-XX-7666	7 Name of employer EMC CORPORATION		8 Employer identification number (EIN) 04-2680009
3 Street address (including apartment no.) 1701 FENTON HILL DRIVE				9 Street address (including room or suite no.) 176 SOUTH STREET		10 Contact telephone number 8559011222
4 City or town LEANDER	5 State or province TX	6 Country and ZIP or foreign postal code US 78641		11 City or town HOPKINTON	12 State or province MA	13 Country and ZIP or foreign postal code US 01748

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)	$ 115.33	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
17 ZIP Code													

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.   Cat. No. 60705M   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. ☒

	(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	VISHAKHA		LADDHA	XXX-XX-7666		X												
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