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Form 1095-C Department of the Treasury Internal Payeous Service	Emp	loyer-Pro	VIDED H o not attach './rs.gov/Fon	Employer-Provided Health Insurance Offer and Cove  ➤ Do not attach to your tax return. Keep for your records.  ➤ Go to www./rs.gov/Form1995C for instructions and the latest information.	ITANCE ITM. Keep for	Offer a	and ords. st infor	mation.	verage <sub>on.</sub>	-					20 <b>17</b>	2017	- 151
Part Employee							Applicab	cable L	arge	ile Large Employer Member (Employer)	yer Me	mber	(Emp	oyer)			
1 Name of employee NAGAHEMANTH KOSANAM	NAM		2 Social	2 Social security number (SSN) ****-**-7787		7 Name of employer NTT DATA, INC.	A, IN						80	Employer 0	8 Employer identification number (EIN) 04-2437166	tion num	ber (EIN)
3 Street address (including apartment no.) 91 FREEDOM DR	nent no.)				0.8	9 Street address (including ONE HUNDRED (	NDRE	DCITY	ing room or suite no.) CITY SQUARE	ARE			5	Contact t (85	10 Contact telephone number (855) 624-7677	number -7677	
4 City or town MONTPELIER	5 State or province	<b>Y</b> ≈	6 Country	6 Country and ZIP or foreign postal code 05602-3351	1	11 City or town	- 5		12 8	12 State or province	MA S		<b>1</b>	Country ar	13 Country and ZIP or foreign postal code 02129	yreign pos	tal code
Parall Employee Offer of Coverage	or of Covera	9				Plan Start Month	자 조 조		er 2-di	(Enter 2-digit number):	er)		ŀ				
All 12 Months	Jan	Feb	Mar	Apr	May	June	-			Aug	Sept	*	8	-	₹		Dec
14 Offer of Coverage (enter required code)	1E	1E	Ħ	1É	m	1É		Æ		Æ	31		π'n		m	_	m
15 Employee Required Contribution (see	* 60 15	80 15	80 45		80 45	60 45	n →	80 15	•	80 15	2	20 20 20 20 20 20 20 20 20 20 20 20 20 2	BO 15	<del>n</del>	20	•	60
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	20	2C	2C	2C	2C	2C		20		2C	20				2C		20
Part III Covered Individuals  If Employer provided self-insured coverage, check the box and enter the information for each individ	duals ded self-insur	red coverage	check the	box and enter t	the informat	tion for ea	ach inc	lividual	enrolle	lual enrolled in coverage, including the employee.	erage,	includir	ng the e	mploye	ě ×	_	
(a) Name of covered individual(s)	vidual(s)	(b) SSN or other TIN	other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	us Jan	Feb	Mar	Apr	(e)	(e) Months of Coverage	of Covera	Aug	Sept	Oct	NON N	Dec
NagaHemanth Kosanam	nam	****-7787	-7787			×	×	×	$\times$	×	×	×	×	×	×	×	×
NIHARIKA KOSANAM	Z			1985-09-07										×	X	×	×
HASININAGA KOSANAM	NAM			2012-09-11										X	×	×	×
20																	
21																	
23																	
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	k Reduction A	ct Notice, see	separate in	structions											F	1095	Form 1095-C (2017)