

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. 1545-2281 **600318**
2019

Part I Employee

1 Name of employee (first name, middle initial, last name)
PIYUSH MAHAJAN

2 Social security number (SSN)
*****-**-6133**

3 Street address (including apartment no.)
59 SLUICE WAY

4 City or town
FOLSOM

5 State or province
CA

6 Country and ZIP or foreign postal code
95630

7 Name of employer
INTEL CORPORATION

8 Street address (including room or suite no.)
2200 MISSION COLLEGE BLVD

9 City or town
SANTA CLARA

10 State or province
CA

11 Contact telephone number
877-466-9236

12 Country and ZIP or foreign postal code
95054

13 Employee identification number (EIN)
94-1672743

Part II Employee Offer of Coverage

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)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C

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	
PIYUSH MAHAJAN	***-**-6133			X	X	X	X	X	X	X	X	X	X	X	X	X

Form 1095-C (2019)

Name of employee (first name, middle initial, last name)
PIYUSH MAHAJAN

Social security number (SSN)
*****-**-6133**

Part III Covered Individuals - Continuation Sheet

(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	
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