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

OMB No. 1545-2251 600117
2017

Part I Employee

1 Name of employee	AMIT MISHRA
2 Social security number (SSN)	***-**-1137
3 Street address (including apartment no.)	400 CAMELOT COURT APT 704
4 City or town	PITTSBURGH
5 State or province	PA
6 Country and ZIP or foreign postal code	15220

Applicable Large Employer Member (Employer)

7 Name of employer	HCL AMERICA INC
8 Employer identification number (EIN)	77-0205035
9 Street address (including room or suite no.)	330 POTRERO AVE
10 Contact telephone number	844-279-7898
11 City or town	SUNNYVALE
12 State or province	CA
13 Country and ZIP or foreign postal code	94085

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, if 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)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	AMIT MISHRA	***-**-1137			X	X	X	X	X	X	X	X	X	X	X	X
18	PRAKHAR MISHRA	***-**-5511			X	X	X	X	X	X	X	X	X	X	X	X
19	VIBHA MISHRA	***-**-5483			X	X	X	X	X	X	X	X	X	X	X	X
20																
21																
22																

(e) Months of Coverage

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2017)

Name of employee: AMIT MISHRA
Social security number (SSN): ***-**-1137

Part III Covered Individuals – Continuation Sheet

	(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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23																
24																
25																
26																
27																
28																
29																
30																
31																
32																
33																
34																

(e) Months of coverage