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 600118

2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	BALAMURUGAN VEDHAPURI
2 Social security number (SSN)	***-**-1607
3 Street address (including apartment no.)	6395 PINE BLUFF DR
4 City or town	CUMMING
5 State or province	GA
6 Country and ZIP or foreign postal code	30040

Applicable Large Employer Member (Employer)

7 Name of employer	RANDSTAD GENERAL PARTNER (US) LLC
8 Employer identification number (EIN)	58-2426265
9 Street address (including room or suite no.)	3625 CUMBERLAND BLVD SUITE 600
10 Contact telephone number	855-594-6213
11 City or town	ATLANTA
12 State or province	GA
13 Country and ZIP or foreign postal code	30339

Plan Start Month (enter 2-digit number): 01

Part II Employee Offer of Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27	$ 120.27
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) 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
17	BALAMURUGAN VEDHAPURI	***-**-1607			X	X	X	X	X	X	X	X	X	X	X	X
18	AADHAN BALAMURUGAN	***-**-0904			X	X	X	X	X	X	X	X	X	X	X	X
19	KAVIYA BALAMURUGAN	***-**-3774			X	X	X	X	X	X	X	X	X	X	X	X
20	ANITHA SOUNDARARAJAN	***-**-3608			X	X	X	X	X	X	X	X	X	X	X	X
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

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Form 1095-C (2018)

Name of employee (first name, middle initial, last name) BALAMURUGAN VEDHAPURI

Social security number (SSN) ***-**-1607

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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