



8EE 0070 MJ263 00000008

000001188 JOB00960
NETWORK TELEPHONE SERVICES INC
21135 ERWIN ST
WOODLAND HILLS, CA 91367



8EEPNA95CPY0000035508A415A118

001623 RO9C8601 8EE 0070 MJ263 00000008
NISHANT S GALA
3860 WATSEKA AVE
APT 1
LOS ANGELES, CA 90034

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

600117

VOID
 CORRECTED

OMB No. 1545-2251
2017

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.

Part I Employee						Applicable Large Employer Member (Employer)					
1 Name of employee NISHANT S GALA			2 Social security number (SSN) XXX-XX-7234			7 Name of employer NETWORK TELEPHONE SERVICES INC			8 Employer identification number (EIN) 95-4188939		
3 Street address (including apartment no.) 3660 WATSEKA AVE						9 Street address (including room or suite no.) 21135 ERWIN ST			10 Contact telephone number 818-227-1145		
4 City or town LOS ANGELES		5 State or province CA		6 Country and ZIP or foreign postal code USA 90034		11 City or town WOODLAND HILLS		12 State or province CA		13 Country and ZIP or foreign postal code USA 91367	

Part II Employee Offer of Coverage						Plan Start Month (Enter 2-digit number): 07							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$ 66.90	\$ 66.90	\$ 66.90	\$ 66.90	\$ 66.90
16 Section 4980H Safe Harbor and Other Rules (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	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. <input type="checkbox"/>															
(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DCB (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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form 1095-C (2017)