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Form 1095-C		Em	ployer-Pi	OVIDED I	Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. The provided Health Insurance and the latest information.	m. Keep to	your rec	orde.		980		δ 	CORRECTED	CTED		2018	8	•
Internal Revenue Service	ice		MM O1 OĐ ♠	W.H. BOOK	Applicable			Applicable		Large Employer Member (Employer)	mploy	er Me	mber (Emplo	Yes.			
1 Name of employe	Employee first name	middle initial, last	t name)	2 Socia	2 Social security number (SSN)		7 Name of employer	mployer			5			8 E	nployer ide	entification	8 Employer Identification number (EIN)	
KIRAN KUMAR PASUPUNOOTI	AR PASU	PUNOOTI		156	156-19-3798		PARADIGM INFO	DIGM	NFO	TECH INC	ဂ်			5	52-2118672	672		
3 Street address (including spartment no.)	duding apartr	nent no.)					9 Street address (including room or suite no.)	rese (incl		m or suite	3			100	10 Contact talephone number	chone nur	aber	
1287 ELDAMAR CT	AR CT					_	8830 STANFORD	MAIS		BLVD STE 312	1E 312			2	(410) 872-1008	2-1008		
4 City or town		5 State or province	6	8 Countr	6 Country and ZIP or foreign poetal code		11 City or town	1		12 Stat	12 State or province	nce		13 Co.	intry and ZI	P or foreign	13 Country and ZIP or foreign postal code	
SAN JOSE		CA		SU	95121		COLUMBIA	MBIA		M	0			SU	\$ 21045	5		
Paralli Emplo	yee Offe	Employee Offer of Coverage	99			_	Plan Start Month (en	A Mon	th (ente	ter 2-digit number):	t numb	37):						
	All 12 Months	Jan	Feb	Mar	Apr	May	eunf		July	Aug	9	Sept	\vdash	ξţ	NOV	_	Dec	
Offer of overage (enter quired code)		1E	1E	m	1E	1E	Æ		₩	Ħ		Ħ		Æ	16		Æ	
Employee quired ntribution (see tructions)		\$45.00	\$45.00	\$45.00	\$45.00 \$	\$45.00	\$ 45.00	\$45.00		\$ 45.00	4	\$60.00	\$60.00		\$60.00	\$ 60.00	.8	
Section 4980H is Harbor and her Relief (enter de, if applicable)		20	20	20	20	20	20		20	20		20	N	20	26	-	20	and the second s
art III Coven	Covered Individuals If Employer provided se	duals ded self-insu	red coverag	e, check the	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	he informat	on for ea	ch indiv	idual en	rolled in	covera	overage, including	ding th	e empl	оуее.			
(a) Name of covered individual(s) First name, middle initial, last name	(a) Name of covered individual(s) irst name, middle initial, last nam	vidual(s) ast name	(a) SSN	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	er (d) Covered	Jan	종	Mar	ð.	May Ju	June July	ly Aug	g Sept	Oct Oct	NOV.	Dec	
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2	DANAMO	erwork Reduction Act Notice, see separate instructions.	Act Notice,	ee separate	instructions.				Cat. N	No. 60705M					8	A 1000		