Form 1095-C
Department of the Treasury
Internal Revenue Service
Part I Employee

Employer identification number (EIN)	8 Employer	7 Name of employer	2 Social security number (SSN)	mployee (first name, middle initial, last name)	mployee (first name, r
(Carl	Over Member (Emple	פמשפ			Employee
		and the latest information.	▶ Go to www.irs.gov/Form1095C for instructions and the latest information.	▶ Go to и	lue Service
9	CORRECTED	for your records.	Do not attach to your tax return. Keep for your records.		f the Treasury
OMB No. 1545-2251		e Offer and Coverage	Employer-Provided Health Insurance Offer and Coverage	Employer-F	
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1 Name of employee (first name, middle initial, last name) Hariharasudhan Shanmugan	de initial, last name) Shanmugam	yam	2 Social secur ***-**-6740	2 Social security number (SSN) ***-**-6740		7 Name of employer ACADEMY LTD	TD			8 Employer ider 74-1670067	8 Employer identification number (EIN) 74-1670067	number (EIN)
3 Street address (including apartment no.) 4315 Glenirish Drive	no.)			When the second		9 Street address (including room or suite no.) 1800 N Mason Road	Including room n Road	or suite no.)		10 Conta (281) S	10 Contact telephone number (281) 944-6726	nber
4 City or town 5 St Katy TX	5 State or province TX	WOOD 100000000000000000000000000000000000	6 Country and US 77494	6 Country and ZIP or foreign postal code US 77494	ostal code	11 City or town Katy		12 State or province	vince	13 Country and US 77449	13 Country and ZIP or foreign postal code US 77449	n postal code
Part II Employee Offer of Coverage	of Coverag	е	- Constitution of the cons			Plan Start Month (enter 2-digit number):	onth (enter	2-digit numb	per):			
All 12 Months	Jan	Feb	Z P	Apr	May	June	SIIV	A (	Sent	3	Nov	7
14 Offer of Coverage (enter required code)	主	<b></b>	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	69	<del></del>	€>	↔		<del>Ο</del>			9 9	s e		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2A	2D	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
Part IIII Covered Individuals	als											

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			Shridhama	Ananya	Hariharasudha	(a) Name of cov First name, middl	If Employe
			Hariharasudha	Hariharasudha ***-**-8497	Shanmugam	(a) Name of covered individual(s) First name, middle initial, last name	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.
A.			***_**_7627	***_**-8497	***-**-6740	(b) SSN or other TIN	d coverage, check the
						(c) DOB (if SSN or other TIN is not available) all 12 months	ne box and enter th
						all 12 months	le informati
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						Feb	ach inc
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	[]		×	×	X	Apr	enrolle
			X	×	X	May (e)	d in cov
			×	×	X	Months of	erage,
			×	×	×	(e) Months of Coverage	includir
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			X	X	X	Sept	mploye
			X	X	×	Oct	ee.
			×	×	×	Nov	
			X	×	×	Dec	

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Cat. No. 60705M

Form 1095-C (2019)