

Part I Employee		2 Social security number (SSN) ***-**-9119	Applicable Large Employer Member (Employer)				8 Employer identification number (EIN) 77-0205035
1 Name of employee BALAJI ANNAMALAI		7 Name of employer HCL AMERICA INC		9 Street address (including room or suite no.) 330 POTRERO AVE		10 Contact telephone number 844-279-7898	
3 Street address (including apartment no.) 2325 NASHVILLE PIKE APT 714 STONERIDGE FARMS APARTMENTS		6 Country and ZIP or foreign postal code 37066		11 City or town SUNNYVALE		12 State or province CA	
4 City or town GALLATIN	5 State or province TN	13 Country and ZIP or foreign postal code 94085					

Part II Employee Offer of Coverage		Plan Start Month (Enter 2-digit number): 01											
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

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 checked="" type="checkbox"/>														
17	BALAJI ANNAMALAI	***-**-9119			(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	ISHITHAA BALAJI	***-**-5661			X	X	X	X	X	X	X	X	X	X	X	X
19	ARCHANA PADMANABAN	***-**-8042			X	X	X	X	X	X	X	X	X	X	X	X
20																
21																
22																

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

Part III Covered Individuals - Continuation Sheet																
23					(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
24																
25																
26																
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