Form 1095-C Department of the Treasury	asury	m	ployer-P	Employer-Provided Health Insurance Offer an Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest	lealth Ins ur tax return. 1095C for inst	urance Keep for y	Offer a our records and the lates	nd Coverage					П	CORRECTED	RECT	ŒD	OME	2 No.	No. 1545 <b>2018</b>	OMB No. 1545-2251
Part : Employee	уее							Applicable Large Employer Member (Employer)	able	Larg	e Err	ploy	er N	emb	er (E	dm	loye	ユ		
1 Name of employee (first name, middle initial, last name)  MAHENDER REDDY   ADONDA	(first name, mid	dle initial, last	name)		2 Social security number (SSN)	tty number (9 -5918		7 Name of employer CGI Technologies and Solutions Inc	nd So	lutions	ਨ				8 E	nploye	r ident	r identification 54-0856778	on nur	8 Employer identification number (EIN) 54-0856778
3 Street address (including apartment no.) 6516 PARK SOUTH DRIVE	uding apartment	t no.)					9 Street 11325 F	9 Street address (including room or suite no.) 11325 Random Hills Rd	uding r	o moo	r suite	no.)			10 C	ontac	t telep	hone	10 Contact telephone number	4
4 City or town	-	5 State or province	8		6 Country and ZIP or foreign postal	P or foreign pos		11 City or town		12	12 State or province	or prov	/ince		13 C	ountr	y and	ZIP or	foreig	13 Country and ZIP or foreign postal code
CHARLOTTE	NC NC				US 28210		Fairfax	×		VA					22030	30				
Part il Employee Offer of Coverage	yee Offer of	f Coverag	0	1		•	Plan	Start Month (enter 2-digit number):	th (e	nter :	2-dig	t nur	nber	);				,		
14 Offer of	All 12 Months	Jan	Feb	Mar	Арг	May	June	July		Aug		Sept		Oct	요		Nov	_		Dec
Coverage (enter required code)		Ĥ	1A	1A	1A	1A	i A	i à		1 A		1A		-1	1A		1A			1A
15 Employee Required Contribution (see instructions)		1							1											
16 Section 4980H Safe Harbor and Other Relief (enter		2A				4														
Part III Covere	Covered Individuals  If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.	s self-insured	d coverage, c	heck the box	and enter the	information	n for each i	ndividual enro	lled in	соуе	rage,	incluc	ling t	ie em	ploye	e.		X	7	
(a) A	(a) Name of covered individual(s)	ed individua	il(s)		(b) SSN or other TIN	other TIN or	(c) DOB (if SSN or other TIN is	(d) Covered				(0)	Aonths	(e) Months of Coverage	verage					
	First name, middle initial, last name	initial, last	name		*** ** 70		not available)	all 12 IIIOIII S	Jan	Teb	Mar	Ą	May	June	July	Buy	Sept	ğ	NOV	Cec
17 MAHENDER REDDY		ADONDA			***_**-5918	918			A 10	×	×	×	×	×	×	×	×	×	×	×
		- Applied															/		-	