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OMB No. 1545-2251

Form 1095-C

2017

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

Department of the Treasury
Internal Revenue Service

Part I Employee

Field	Value
1 Name of employee	Shandilya Peddi
2 Social security number (SSN)	098-51-0171
3 Street address (including apartment no.)	403 Boscawen Lane
4 City or town	Cary
5 State or province	NC
6 Country and ZIP or foreign postal code	US 27519

Applicable Large Employer Member (Employer)

Field	Value
7 Name of employer	Tibco Software Inc.
8 Employer identification number (EIN)	77-0449727
9 Street address (including room or suite no.)	3301 Hillview Avenue
10 Contact telephone number	650-846-8669
11 City or town	Palo Alto
12 State or province	CA
13 Country and ZIP or foreign postal code	US 94304

Part II Employee Offer of Coverage

Plan Start Month (Enter 2-digit number): 01

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	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. X

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
17	Shandilya Peddi	098-51-0171		X	X	X	X	X	X	X	X	X	X	X	X	X
18																
19																
20																
21																
22																

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

Name of employee: Shandilya Peddi

Social security number (SSN): 098-51-0171

Part III Covered Individuals - Continuation Sheet

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
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