VOID

600117

OMB No. 1545-2251

Form 1095-C

Department of the Treasury
Internal Revenue Service

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*

CORRECTED

2017

Part I Employee

1 Name of employee	2 Social security number (SSN)
Saineela Nagisetti	XXXXX6209

3 Street address (including apartment no.)
3010 West Yorkshire Dr, Apt # 3100

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Phoenix	AZ	US 85027

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ERP Analysts, Inc.	31-1688884

9 Street address (including room or suite no.)	10 Contact telephone number
425 Metro Pl N , Ste # 510	614-718-9222

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Dublin	OH	US 43017

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)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$156.86	$189.27
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F	2F

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. ☐

	(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																
18																
19																
20																
21																
22																