1005		OVAL DEA	Hard H	Employer-Provided Health Insurance Offer and	Hrance	Offer	0	operado.		MOID	0		OMB No.	OMB No. 1545-2251	3
Department of the Treasury Internal Revenue Service	la Cinio	→ Go to www.	not attach	➤ Do not attach to your tax return. Keep for your records. ➤ Go to www.irs.gov/Form1095C for instructions and the latest information.	urn. Keep for	or your reco	3 (tion.		Cop	CORRECTED	Ö	20	2017	
Part I Employee	ee			P. 19.			Applicabl	ble Large Employer Member (Employer)	Employe	er Memi	ber (Em	ployer)			
1 Name of employee Anurag Dixit			2 Social secur	2 Social security number (SSN) *****5808	SSN	7 Name of employer Incedo, Inc						8 Employer identif 45-4411958	8 Employer identification number (EIN) 45-4411958	tion numb	er (EIN)
3 Street address (including apartments) 130 Kinderkamack Roa	Street address (including apartment no.) 30 Kinderkamack Roa		Apt # 4			9 Street address (including room or suite 2350 Mission College Bly	9 Street address (including room or suite no.) 2350 Mission College Bly	g room or sui	te no.)			10 Contact 805 37	10 Contact telephone number 805 377-1955	number	
4 City or town	5 State or province		6 Country	6 Country and ZIP or foreign postal code		11 City or town	m	12 S	12 State or province	nce	HEST	13 Country	13 Country and ZIP or foreign postal code	reign posta	il code
Westwood	Z		07675			Santa CI	Clara	CA				95054			1
Part II Empl	Employee Offer of Coverage	ge		The second of	THE PERSON NAMED IN	Plan Star	Plan Start Month (Enter 2-digit number): 06	(Enter 2-di	git numb	er): 06			September 1	Mr. In	
	All 12 Months Jan	Feb	Mar	Apr	May	June	July	1	Aug	Sept	Oct	ct	Nov	D	Dec
14 Offer of Coverage (enter required code)	1H	Ŧ	Ť	199	1E	1E	1E	1E		1E	1E	11:	m	1E	1
15 Employee Required Contribution (see Instructions)	49		\$ 100.20\$	\$ 100.20\$	\$ 100.20\$	0\$ 121.45	€9	121.45 \$	121.45\$	121.45	↔	121.45	121.45\$		121.45
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	24	2D	20	2C	2C	2C	2C	20	N	20	2C	2C	0	20	
Part III Cove	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each indivi	ed coverage,	check the	box and enter	the inform	ation for ea	ach individ	dual enrolled in coverage, including the employee.	d in cove	rage, incl	luding th	e employ	/ee.		
(a) Name o	(a) Name of covered individual(s)	(b) SSN or other TIN	other TIN	or other TIN is not available)	(d) Covered all 12 months	red iths Jan	Feb Ma	Mar Apr	May .	(e) Months of Coverage / June July /	July Aug	g Sept	Oct	Nov	Dec
17															
18															
19															
20															
21															
B															
Ear Privacy Act ar	d Paperwork Reduction Act Notice, see separate instructions	ct Notice, see	separate in	structions				Cat No 60705M)5M				Form	Form 1095-C (2017	3 (2017