# 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.

Go to www.irs.gov/Form1095C for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251 600120

2022

**Part I Employee**

| 1 Name of employee (first name, middle initial, last name) | 2 Social security number (SSN) |
|---|---|
| KINJAL THAKKAR | XXX-XX-6139 |

| 3 Street address (including apartment no.) |
|---|
| 301 PARKVIEW LN APT 13B |

| 4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code |
|---|---|---|
| IRVINE | CA | US 92612 |

**Applicable Large Employer Member (Employer)**

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| AMAZON.COM SERVICES LLC | 82-0544687 |
| **9 Street address (including room or suite no.)** | **10 Contact telephone number** |
| PO BOX 81226 | 866-644-2696 |
| **11 City or town** | **12 State or province** |
| SEATTLE | WA |
| | **13 Country and ZIP or foreign postal code** |
| | US 98108 |

**Part II Employee Offer of Coverage**

Employee's Age on January 1:

Plan Start Month (enter 2-digit number): 04

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 Offer of Coverage (enter required code) | | 1E | 1H | 1H | 1H | 1H | 1H | 1H | 1H | 1H | 1H | 1H | 1H |
| 15 Employee Required Contribution (see instructions) | $ | $ 33.00 | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2C | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A | 2A |
| 17 ZIP Code | | | | | | | | | | | | | |

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2022)



**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) First name, middle initial, last name | (b) SSN or other TIN | (c) DOB (if SSN or other TIN is not available) | (d) Covered all 12 months | (e) Months of coverage Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KINJAL THAKKAR | XXX-XX-6139 | | | X | | | | | | | | | | |
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☐ VOID
☐ CORRECTED

OMB No. 1545-2251 600320

2022

**Part I** Employee

| 1 Name of employee (first name, middle initial, last name) | | 2 Social security number (SSN) |
|---|---|---|
| KINJAL | THAKKAR | XXX-XX-6139 |
| 3 Street address (including apartment no.) | | |
| 412 DEERFIELD AVENUE | | |
| 4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code |
| IRVINE | CA | US 92606 |

**Applicable Large Employer Member (Employer)**

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| ERNST & YOUNG US LLP | 34-6565596 |
| 9 Street address (including room or suite no.) | 10 Contact telephone number |
| ONE MANHATTAN WEST | 18553144222 |
| 11 City or town / 12 State or province | 13 Country and ZIP or foreign postal code |
| NEW YORK / NY | US 10001 |

**Part II** Employee Offer of Coverage — Employee's Age on January 1: — 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) | | 1H | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E | 1E |
| 15 Employee Required Contribution (see instructions) | $ | $ | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 | $ 61.00 |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | 2D | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C | 2C |
| 17 ZIP Code | | | | | | | | | | | | | |

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**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) First name, middle initial, last name | | | (b) SSN or other TIN | (c) DOB (if SSN or other TIN is not available) | (d) Covered all 12 months | (e) Months of coverage | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| KINJAL | | THAKKAR | XXX-XX-6139 | | | | X | X | X | X | X | X | X | X | X | X | X |
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