

# Employer-Provided Health Insurance Offer and Coverage

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

Go to [www.irs.gov/Form1095C](http://www.irs.gov/Form1095C) for instructions and the latest information.

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**Part I** Employee

**Applicable Large Employer Member (Employer)**

1 Name of employee (first name, middle initial, last name) VAIBHAV RAJ MATHUR		2 Social security number (SSN) XXX-XX-6117		7 Name of employer AMAZON.COM SERVICES LLC		8 Employer identification number (EIN) 82-0544687	
3 Street address (including apartment no.) 800 SENECA STREET UNIT 2302				9 Street address (including room or suite no.) PO BOX 81226		10 Contact telephone number 866-644-2696	
4 City or town SEATTLE		5 State or province WA		11 City or town SEATTLE		12 State or province WA	
6 Country and ZIP or foreign postal code US 98101				13 Country and ZIP or foreign postal code US 98108			

**Part III** 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
Offer of Coverage (after required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
Employee Required contribution (see instructions)	\$	\$ 31.00	\$ 31.00	\$ 31.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00	\$ 33.00
Section 4980H Safe harbor and Other relief (enter code, applicable)	2C												
ZIP Code													

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

Cat. No. 60705M

Form 1095-C (2021)

**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			
18	VAIBHAV RAJ MATHUR	XXX-XX-6117		X															
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