

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

600120
OMB No. 1545-2251

2022

Part I Employee				Applicable Large Employer Member (Employer)			
1 Name of employee (first name, middle initial, last name) Ayaz Uddin		2 Social security number (SSN) XXX-XX-7160		7 Name of employer K Health Inc		8 Employer identification number (EIN) 81-4173541	
3 Street address (including apartment no.) 2244 35th St 2r,				9 Street address (including room or suite no.) 125 W 25th St, Fl 7		10 Contact telephone number 206-779-4482	
4 City or town Astoria	5 State or province NY	6 Country and ZIP or foreign postal code 11105		11 City or town New York	12 State or province NY	13 Country and ZIP or foreign postal code 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)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1H
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	2A
17 ZIP Code													

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

Cat. No. 60705M

Form **1095-C** (2022)