Department of the Treasury Internal Revenue Service Part I Employee

Employer-Provided Health Insurance Offer and Coverage
Do not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form 1095C for Instructions and the latest information.

OMB No. 1545-2251

021009

2022

Part III Covered Individuals  If Employer provided sel  (a) Name of covered individual(s)  First name, middle initial, last name  Mugdha  Warpe  19  20  21	quired principles (a) First Mugd	quired ructions) Section 49, le Harbor an art III  (a) First  Mugd	quired ructions) Section 49, 49, 46 Harbor an Helief (e. le., if applico ZIP Code ant III  (a) First  Mugd	quired ructions) Section 49, le Harbor al rapplic de, if applic de, if applic Application Applicatio	required Contribution (see instructions)  16 Section 4980H Safe Harbor and Other Haller (enter code, if applicable)  17 ZIP Code  Part III Covers  If Employers  First name, m	A required Contribution (see instructions)  16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)  17 ZIP Code  Part III Covert  If Employers  (a) Name of First name, m	17 ZIP Code  Part III Covere  Temple  Temple  Temple	required Contribution (see instructions)  16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)  17 ZIP Code  Part IIII Covery	-	9		15 Employee	required code)	14 Offer of	A	Parit Emplo	12	4 City or town	275 MAIN ST APT 303	3 Street address (including apartment no.)	1 Name of employee (first name, middle initial, last name)
					Varpe		(a) Name of covered individual(s) irst name, middle initial, last name	yer provided	d Individu	1 1		45			All 12 Months	ee Offer o		CT	T 303	ding apartment	irst name, midd
					)e		ial(s) name	d self-insure	ole	1 1 1 1	2C	78.78 \$	1E		Jan	<b>Employee Offer of Coverage</b>	MA	State or province	no.)	מחסו	VARPE
					****-1270		(b) SSN or other TIN	d coverage,		1 1 1	20	78.78 \$	1E		Feb	le	A				ime)
					-1270		other TIN (c	check the		1 1 1 1	2C	78.78 \$	1E		Mar			6 Country			2 Social s
							(c) DOB (if SSN or other (d) Covered	If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.		1 1 1 1		\$ 78.78 \$	1E	NOT THE	Any Age on January 1	mplovagia	02472-4344	and ZID or tour		****_**-1270	2 Social security number (SSN)
						on in indiana	ther (d) Cover	r the inform		1 1 1			1E	May	Age on Ja						
]					×	Jan	ed	ation for ea		1 1 1 1			îE	June	anuary 1	WATERTOWN	11 City or town	311 ARSENAL S	Street addre	ATHENAHEAL	P
					X	reb Mar		ıch individu					1E	July		NWO		NAL ST.	9 Street address (including room or suite no.)	ATHENAHEALTH INC	Applicable Large Employer Member (Employer)
					×	Apr		al enrolle			•	78 78 4	_		Plar		12 Sta		room or suite	No.	Large E
]					×	May	(e) N	d in cove			2C	78 78 4	m	Aug	Plan Start Month (enter 2-digit number): 01	N	12 State or province		no.)		mployer
					×	June	(e) Months of coverage	rage, inc			20	78 7	m	Sept	fonth (e	MA	00				Memb
					X	July Aug	overage	luding th			6	A .	16	Oct	nter 2-di		1:		4	80	er (Emp
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					×	pt Oct					2C		î î	Nov	ber): 01	02472	13 Country and ZIP or foreign postal code	617) 402-1000	10 Contact telephone number	8 Employer identification number (EIN)	
					×	Nov	+	×			6	A	_	D		2	reign posta	-1000	umber	ion numbe	
					×	Dec	+				20	78 78	m	Dec			code			r (EIN)	