

N-ABLE TECHNOLOGIES INC
30 CORPORATE DRIVE SUITE 400
BURLINGTON, MA 01803



8PCPNA95CPO0000005119A441A155

002307 RO9MU001 8PC 0030 A5436 000000054
TATYANA BUSEL JONGSMA
851 BRIGHT WATERS
BLVD NE
SAINT PETERSBURG, FL 33704

Please verify that your name is as it appears on your social security card and matches records maintained with your employer.

600120

☐ VOID

OMB No. 1545-2251

☐ CORRECTED

2022

Form **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.**Part I Employee****Applicable Large Employer Member (Employer)**

1 Name of employee (first name, middle initial, last name) TATYANA BUSEL JONGSMA		2 Social security number (SSN) XXX-XX-2374		7 Name of employer N-ABLE TECHNOLOGIES INC		8 Employer identification number (EIN) 95-4547068	
3 Street address (including apartment no.) 851 BRIGHT WATERS		6 Country and ZIP or foreign postal code USA 33704		9 Street address (including room or suite no.) 30 CORPORATE DRIVE SUITE 400		10 Contact telephone number 512-498-6347	
4 City or town SAINT PETERSBURG	5 State or province FL	6 Country and ZIP or foreign postal code USA 33704		11 City or town BURLINGTON	12 State or province MA	13 Country and ZIP or foreign postal code USA 01803	

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) 1E													
15 Employee Required Contribution (see instructions) \$ 0.00													
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C													
17 ZIP Code													

Part III Covered IndividualsIf 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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	