

Solarwinds MSP US, Inc.
7171 Southwest Pkwy, Bldg 400
Austin, TX 78735

Tatyana Busel Jongsma
851 Brightwaters Blvd NE
Saint Petersburg, FL USA 33704

600120

Form 1095-C

Employer-Provided Health Insurance Offer and Coverage

☐ VOID☐ CORRECTED

OMB No. 1545-2251

2020

Department of the
Treasury
Internal Revenue Service

► 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 Solarwinds MSP US, Inc.		8 Employer identification number (EIN) 95-4547068	
3 Street address (including apartment no.) 851 Brightwaters Blvd NE				9 Street address (including apartment no.) 7171 Southwest Pkwy, Bldg 400		10 Contact telephone number 512-682-9300	
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 Austin	
				12 State or province TX		13 Country and ZIP or foreign postal code USA 78735	

Part II Employee Offer and Coverage				Employee's Age on January 1				Plan Start Month: 01					
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
1E													
15 Employee Required Contribution (see instructions)	\$	\$105.00	\$105.00	\$105.00	\$105.00	\$105.00	\$105.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												
17 ZIP Code													

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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
18			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, see the additional covered individuals on Part III, Continuation Sheet(s).