

Form
1095-C**Employer-Provided Health Insurance Offer and Coverage**Department of the Treasury
Internal Revenue ServiceDo not attach to your tax return. Keep for your records.
Go to www.irs.gov/Form1095C for instructions and the latest information.

OMB No. 1545-2251

2025☐ VOID
☐ CORRECTED**Part I Employee**

1 Name of employee (first name, middle initial, last name) Vivek	2 Social security number (SSN) XXX-XX-7440	7 Name of employer Moore Capital Management, LLC	8 Employer identification number (EIN) 84-4686218
3 Street address (including apartment no.) 20 Farmhaven Avenue		9 Street address (including room or suite no.) Eleven Times Square Floor 38	10 Contact telephone number 212-782-6075

4 City or town Edison	5 State or province NJ	6 Country and ZIP or foreign postal code US 08820	11 City or town New York	12 State or province NY	13 Country and ZIP or foreign postal code US 10036
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Part II Employee Offer of Coverage

	All 12 Months	Employee's Age on January 1												Plan Start Month (enter 2-digit number): 01	
		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) \$ 31.38	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C															
17 ZIP Code															

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

Cat. No. 60705M

Form **1095-C** (2025) Created 5/21/25

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					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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