

2020 Form MA 1099-HC Individual Mandate - Massachusetts Health Care Coverage

1 Name of insurance company or administrator Blue Cross Blue Shield of Massachusetts		2 FID number of insurance co. or administrator 04-1045815		
3 Name of subscriber HEMANTH LAM	4 Date of birth 05/24/1998	5 Subscriber number XXXXXXXXXXXX		
6 Street address 29 RUTLEDGE RD	7 City/Town NATICK	8 State MA	9 Zip 01760	
Full-year minimum creditable coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If No, check months with minimum creditable coverage: <input type="checkbox"/> Jan. <input type="checkbox"/> Feb. <input type="checkbox"/> Mar. <input type="checkbox"/> Apr. <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug. <input type="checkbox"/> Sept. <input type="checkbox"/> Oct. <input type="checkbox"/> Nov. <input type="checkbox"/> Dec.		Corrected: