

Form MA 1099-HC  
Individual Mandate  
Massachusetts Health Care Coverage

2020  
Massachusetts  
Department of  
Revenue

Tracking #: 3204921T1  
1 Name of insurance company or administrator  
2 FID number of insurance co. or administrator

Tufts Health Public Plans, Inc.  
3 Name of subscriber  
4 Date of birth  
5 Subscriber number

SAILEKHA ANTHAM  
6 Street address  
7 City/Town  
8 State  
9 Zip

CORNELIA COURT MISSION MAIN  
BOSTON  
MA  
021202120

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

a. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

b. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

c. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

d. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

e. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

f. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

g. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

h. Name of dependent  
Date of birth  
Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage:  
Corrected:  
 Yes  No  Jan.  Feb.  Mar.  Apr.  May  June  July  Aug.  Sept.  Oct.  Nov.  Dec.

i. Name of dependent  
Date of birth  
Subscriber number