Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ Do not attach to your tax return. Keep for your records.

▶ Go to *www.irs.gov/Form1095B* for instructions and the latest information.

☐ VOID

☐ CORRECTED

OMB. No. 1545-2252

2020

Part I Responsible Individual

TRACKING #: 4678657T2

1 Name of responsible individual- First name, middle name, last name	2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
AJOSH PALIS	XXX-XX-2001	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
3155 BAYONET CT	MARIETTA	GA	US 30068

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . ▶ B

9 Reserved

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name	11 Employer identification number (EIN)
TALENTQUEST, LLC	XX-XXX5394

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code
1360 PEACHTREE ST NE STE 200	ATLANTA	GA	US 30309

Part III Issuer or Other Coverage Provider (see instructions)

16 Name	17 Employer identification number (EIN)	18 Contact telephone number
HUMANA INC	61-0647538	

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
PO BOX 14750	LEXINGTON	KY	US 40512

Part IV Covered Individuals (Enter the information for each covered individual.)

	(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
23	AJOSH PALIS	XXX-XX-2001		X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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