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

560118
OMB No. 1545-2252

2020

Part I Responsible Individual

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)
VAISHNAVI		GINUGU	***-**-2093	
4 Street address (including apartment no.) 2409 PLAZA DR	**5** City or town WOODBRIDGE		**6** State or province NJ	**7** Country and ZIP or foreign postal code UNITED STATES 07095
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)
FORMAC INC			46-2516265
12 Street address (including room or suite no.) 6201 BONHOMME RD 474S	**13** City or town HOUSTON	**14** State or province TX	**15** Country and ZIP or foreign postal code 77036

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
UnitedHealthcare, Inc.		41-1922511	866-633-2446
19 Street address (including room or suite no.) 601 Brooker Creek Blvd	**20** City or town Oldsmar	**21** State or province FL	**22** Country and ZIP or foreign postal code UNITED STATES 34677

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 VAISHNAVI		GINUGU	***-**-2093		X												
24 SURESH REDDY		BYREDDY	***-**-0236		X												