

If you have any questions, please call us toll-free at the phone number on your health plan ID card. TTY users can dial **711**.

Sincerely,
UnitedHealthcare

Enclosures: Form 1095-B
Form 1095-B information sheet
Social Security Number Request Form
Return envelope

12/08/2020

Important Tax Information

Under the federal health reform law and under certain state laws UnitedHealthcare must report which individuals had a plan with minimum essential coverage. UnitedHealthcare must report this information about your minimum essential coverage on Form 1095-B to the IRS and certain state tax agencies. Certain states may use this information to administer their health care laws.

What is minimum essential coverage?

Minimum essential coverage may include health insurance through a government-sponsored program, eligible employer-sponsored plan, individual market plan or other coverage designated by the Department of Health and Human Services. Your UnitedHealthcare plan is minimum essential coverage.

What is Form 1095-B?

This is an IRS form that shows the health care information that is shared with the IRS and certain state tax agencies. Certain states may use this information to administer their health care laws.

The form shows this information about your health insurance:

- Type of coverage you had
- Period of coverage
- Who was covered (including dependents)

Why did you get more than one Form 1095-B?

You may have been covered under more than one policy during the year. You will get a separate Form 1095-B for each policy.

Will dependents over age 18 covered under your plan get a separate copy of this form?

Dependents over age 18 covered under your plan will **not** get a separate copy of Form 1095-B. You should give a copy to individuals covered under your plan, if they need it for their records.

What if you had minimum essential coverage with another company?

You should receive a form 1095 from any other company that provided you minimum essential coverage.

What if you didn't have minimum essential coverage for the entire year?

Beginning with the 2019 tax year, the IRS penalties have been reduced to zero. Certain states, however, have enacted their own health care laws that require minimum essential coverage and may impose a penalty. For more information, contact your tax advisor or state tax agency.

Can you get this form electronically?

We encourage you to choose to get this form electronically. For more information about electronic delivery, please visit myuhc.com.

Will this form be sent again next year?

You will get a form 1095 every year from any company that provided you minimum essential coverage.

Questions?

If you have any questions, please call us toll-free at the phone number on your health plan ID card. TTY users can dial **711**.

This communication is not intended, nor should it be construed, as legal or tax advice. Please contact a legal or tax professional for legal advice, tax treatment and restrictions. Federal and state laws and regulations are subject to change. You may also visit IRS.gov or your state tax agency.

Social Security Number Request Form

Important Tax Information

Under the federal health reform law and under certain state laws UnitedHealthcare must report which individuals had a plan with minimum essential coverage. Your UnitedHealthcare plan is minimum essential coverage. UnitedHealthcare must report this to the Internal Revenue Service (IRS) and certain state tax agencies. To report, we need Social Security numbers for all members covered under your health plan. If you didn't have coverage or it's not reported, you may have to pay a fee when you file your taxes.

Here's what to do:

Below is a list of members covered under your plan who do not have a Social Security number on file with us. If anyone covered under your plan is not listed, it is because we already have their Social Security number.

For each member listed:

- **If the member has a Social Security number:**
Write the Social Security number in the column called "SSN" on the same line with that person's name.
- **If the member does not have a Social Security number:**
Place a check mark in the column called "Does Not Have an SSN" on the same line with that person's name.

<u>Name</u>	<u>Date of Birth</u>	<u>SSN</u>	<u>Does Not Have an SSN</u>
JANANI NARASIMAN	12/26/1992		
SHARWIN ARUN	07/04/2020		

Certification: I certify that the information included above is complete and accurate, including any information about an individual(s) who does not have a Social Security number (SSN) or individual taxpayer identification number (TIN) used by the IRS in the administration of U.S. tax law.

Person completing this form: _____
(Please Print)

Signature: _____ Date: _____

If you are going to mail this form to us, please turn this page over for instructions.

1. FOLD ALONG THIS LINE TOWARD THE FORM ON THE BACK OF THIS SHEET

UnitedHealthcare, Inc.
P.O. Box 30963
Salt Lake City, UT 84130-0963
USA

2. FOLD ALONG THIS LINE TOWARD THE FORM SO ADDRESS ABOVE SHOWS

3. PLACE IN ENVELOPE SO ADDRESS SHOWS THROUGH THE WINDOW

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

2020

Part I Responsible Individual

1 Name of responsible individual—First name, middle name, last name ARUN MAHENDRAN		2 Social security number (SSN) or other TIN ***-**-0429	3 Date of birth (if SSN or other TIN is not available)
4 Street address (including apartment no.) 10715 N MACARTHUR BLVD APT 250	5 City or town IRVING	6 State or province TX	7 Country and ZIP or foreign postal code UNITED STATES 75063
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ▶ <input type="checkbox"/> B		9 Reserved	

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

10 Employer name INFOVISION INC		11 Employer identification number (EIN) 75-2614700	
12 Street address (including room or suite no.) 800 E CAMPBELL RD STE 388	13 City or town RICHARDSON	14 State or province TX	15 Country and ZIP or foreign postal code 75080

Part III Issuer or Other Coverage Provider (see instructions)

16 Name UnitedHealthcare, Inc.		17 Employer identification number (EIN) 41-1922511	18 Contact telephone number 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 ARUN MAHENDRAN	***-**-0429		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24 JANANI NARASIMAN		12/26/1992	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
25 SHARWIN ARUN		07/04/2020	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
26 ARJUNAN ARUN	***-**-8541		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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

Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as “minimum essential coverage”) for some or all months during the year. Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage.

Before 2019, individuals who did not have minimum essential coverage and did not qualify for an exemption from this requirement could be liable for the individual shared responsibility payment. Beginning in 2019, individuals will not be responsible for the individual shared responsibility payment because the payment amount is reduced to \$0. However, if individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).



Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, and the premium tax credit, see www.irs.gov/ACA or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)



If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage generally will be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer’s EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

