



Form MA 1099-HC Individual Mandate Massachusetts Health Care Coverage

2021	
Massachusett	S
Department o	L
Revenue	

Name of insurance company or administrator UnitedHealth Group	2 FID number of insurance co. or administrator 960000161		
3 Name of subscriber		300000101	
FNU NADIRA FATHIMA	4 Date of birth	5 Subscriber number	
	23NOV1994	0932454444195353485	5
6 Street address	7 City/Town	8 State	9 Zip
6 JUDITH LANE APT 05	WALTHAM	MA	024520000
Full-year minimum creditable coverage? If No b.	TTT IT IT IT		
Full-year minimum creditable coverage? If No, check	k months with minimum credi		Corrected:
	X May June July	Aug. Sept. Oct. Nov.	Dec. N
a. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable covernge? If No.			8
Full-year minimum creditable coverage? If No, chec	k months with minimum credi	table coverage:	Corrected:
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, chec	k months with minimum credit	table coverage:	Corrected:
Yes No Jan. Feb. Mar. Apr			Dec.
	. May June July	Aug. Sept. Oct. Nov.	Dec.
c. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable coverage? If No, chec	k months with minimum credit	table coverage:	Corrected:
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d. Name of dependent	Date of birth	Subscriber number	
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Yes No Jan. Feb. Mar. Apr			Dec.
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e. Name of dependent	Date of birth	Subscriber number	
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Full-year minimum creditable coverage? If No, check			Corrected:
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f. Name of dependent	Date of birth	Subscriber number	
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g. Name of dependent	Date of birth	Subscriber number	
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h. Name of dependent	Date of birth	Subscriber number	
Full-year minimum creditable coverage? If No, check	manus annus annus	able coverage;	Corrected:
Yes No Jan. Feb. Mar. Apr	. May June July	Aug. Sept. Oct. Nov.	Dec.