

2021 Form MA 1099-HC Individual Mandate — Massachusetts Health Care Coverage

1 Name of Insurance company or administrator Blue Cross Blue Shield of Massachusetts		2 FID number of Insurance co. or administrator 04-1045815	
3 Name of subscriber SAI SURYA MOUNI DANDYALA		4 Date of birth 11-14-1995	5 Subscriber number 9624151150000
6 Street address 93 PRESIDENTIAL DR UNIT 2		7 City/Town QUINCY	8 State MA
			9 Zip 02169

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.

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