Wellfleet Group LLC,
PO BOX 15369
WELLFLEET Springfield MA 01115

Forwarding Service Requested

18

SHRAVYA KADUR
165 BRITTANY MNR
APT A1
AMHERST MA 01002

Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2021
Massachusetts Department of Revenue

1. Name of Insurance Company or Administrator	2. FID Number of Insurance Co. or Administrator
Wellfleet Insurance Company	**043187843**

3. Name of Subscriber	4. Date of Birth	5. Subscriber Number
SHRAVYA KADUR	**01/09/1997**	**00181286400**

6. Street Address	7. City/Town	8. State	9. Zip
165 BRITTANY MNR	**AMHERST**	**MA**	**01002**

Name of Subscriber	Date of Birth	Subscriber Number	Coverage Effective Date	Coverage Through Date	Corrected
SHRAVYA KADUR	**01/09/1997**	**00181286400**	**01/01/2021**	**07/31/2021**	☐

Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2021
Massachusetts
Department of
Revenue

1 Name of insurance company or administrator
UnitedHealth Group

2 FID number of insurance co. or administrator
960000161

3 Name of subscriber
SHRAVYA KADUR

4 Date of birth
09JAN1997

5 Subscriber number
09255171131952960378

6 Street address
47 CHURCH ST APT 2

7 City/Town
HUDSON

8 State
MA

9 Zip
017490000

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. Y

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.

BANK OF AMERICA, N.A.
C/O HEALTH ACCOUNT SERVICES
PO BOX 2203
FARGO ND 58108

TAX STATEMENT FOR YEAR 2021

THIS STATEMENT REPORTS 1099-SA (OMB No. 1545-1517),
DEPARTMENT OF THE TREASURY-INTERNAL REVENUE SERVICE.

BANK OF AMERICA BANK# 07202

PAYER'S E.I.N.
94-1687665

SHRAVYA KADUR
836 MANOR AVE N
CLAYMONT DE 19703

CUSTOMER SERVICE PHONE NUMBER
1-800-718-6710

TAXPAYER'S IDENTIFICATION NUMBER
***-**-9113

For Form 1099-SA: This information is being furnished to the IRS.

2021 - 1099-SA, DISTRIBUTIONS FROM AN HSA, ARCHER MSA, OR MEDICARE ADVANTAGE MSA

	ACCOUNT NUMBER	
HSA ACCOUNT	000010000679749	
BOX 1	GROSS DISTRIBUTION	62.82
BOX 3	DISTRIBUTION CODE	1
BOX 5	HSA	X

SHRAVYA KADUR

PLEASE NOTE: INQUIRIES REGARDING THESE ACCOUNTS SHOULD BE DIRECTED TO OUR CUSTOMER SERVICE PHONE NUMBER ABOVE. PLEASE CHECK YOUR TAXPAYER IDENTIFICATION NUMBER AND CALL THE NUMBER LISTED ABOVE IF IT IS INCORRECT.

TDD HEARING IMPAIRED PLEASE CALL 1-800-305-5109

THIS INFORMATION IS BEING FURNISHED TO THE INTERNAL REVENUE SERVICE