

Health Coverage

VOID

CORRECTED

OMB No. 1545-2252

2021

Department of the Treasury
Internal Revenue Service

▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095B for instructions and the latest information.

TRACKING #: 502288911

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)

HENIL VIPUL SHAH

XXX-XX-6402

7 Country and ZIP or foreign postal code

4 Street address (including apartment no.)

5 City or town

6 State or province

9 Reserved

11 Employer identification number (EIN)

455 14TH ST NW UNIT 365

ATLANTA

GA

US 30318

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

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): ▶ **B**

11 Employer identification number (EIN)

12 Street address (including room or suite no.)

13 City or town

14 State or province

15 Country and ZIP or foreign postal code

ASTRA GROUP INC

WOODSTOCK

GA

US 30188

300 CHURCHILL CT

Part III Issuer or Other Coverage Provider (see instructions)

16 Name

17 Employer identification number (EIN)

18 Contact telephone number

19 Street address (including room or suite no.)

20 City or town

21 State or province

22 Country and ZIP or foreign postal code

HUMANANA INC

LEXINGTON

61-0647538

502-580-4470

PO BOX 14750

LEXINGTON

KY

US 40512

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 HENIL VIPUL SHAH

XXX-XX-6402

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Discrimination is Against the Law

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Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filling a grievance, call the number on your ID card or if you use a TTY, call 711.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

HUMANA INC
PO BOX 14760
LEXINGTON, KY 40512

IF YOU HAVE QUESTIONS CONTACT
HUMANA AT 1-800-448-6262

AV 01 039650 24244B141 C**6DGT



FENIL VIPUL SHAH
465 14TH ST NW UNIT 365
ATLANTA, GA 30318

Form 1095-B (2021)

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).

TIP

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 (800-819-0452).

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)

TIP

If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally 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 16 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 1 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.

Astra Group, LLC
 46 S. Rolling Meadows Drive
 Fond du Lac, WI 54937

0016518**000055**000002*****AUTO**ALL FOR AADC 303**000002



0016518

FENIL VIPUL SHAH
 455 14TH ST NW UNIT 365
 ATLANTA GA 30318-7992

600120

Form 1095-C

Employer-Provided Health Insurance Offer and Coverage

VOID

CORRECTED

OMB No. 1545-2251

2021

Department of the Treasury
 Internal Revenue Service

▶ Do not attach to your tax return. Keep for your records
 ▶ Go to www.irs.gov/Form1095C for instructions and the latest information.

Part I Employee				Applicable Large Employer Member (Employer)				
1 Name of employee (first name, middle initial, last name) FENIL VIPUL SHAH		2 Social security number (SSN) xxx-xx-6402		7 Name of employer Astra Group, LLC		8 Employer identification number (EIN) 58-2099418		
3 Street address (including apartment no.) 455 14TH ST NW UNIT365				9 Street address (including apartment no.) 46 S. Rolling Meadows Drive		10 Contact telephone number 920.924.3690		
4 City or town ATLANTA		5 State or province GA	6 Country and ZIP or foreign postal code USA 30318		11 City or town Fond du Lac	12 State or province WI	13 Country and ZIP or foreign postal code US 54937	

Part II Employee Offer and Coverage	Employee's Age on January 1												Plan Start Month: 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2D	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code															

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

(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	
18 FENIL VIPUL SHAH	xxx-xx-6402		<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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