VAFIRS01 COMB 1235 20230126808 J131 20230112 097278 1235 EN [18,012] 2 of 3

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Form I CUU-D		Health Coverage	verago	e						VOID			NID INC. I	010	
Department of the Treasury Internal Revenue Service	Do not a	Do not attach to your tax return, Keep for your records, Go to www.irs.gov/Form1095B for instructions and the latest information.	n. Keep for ctions and	your re	cords,	mation			0	CORRECTED	CTED		2022	2	
Part I Responsible Individual	E.											-			
e of n	le name, last name			2	Social sec	urity num	ber (SSN)	Social security number (SSN) or other TIN	3		birth (if So	SN or oth	Date of birth (if SSN or other TIN is not available)	not availai	ole)
RAHUL		DUMPALA			*****3189	99			. 54						
4 Street address (including apartment no.)		5 City or town		6	State or province	province			7	Country	and ZIP	or foreig	Country and ZIP or foreign postal code	ode	
20 MILEN PARTY SOOTH WET 4007		JEKSEY CILY			Reserver					07310					
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):	Coverage (see instructi	ons for codes):	в	9	Heserved										
Part II Information About Certain Employer-Sponsored Coverage (see instructions)	n Employer-Spon	sored Coverage (see instru	ctions											
10 Employer name BOLT FINANCIAL INC CA DOS									11	11 Employe	yer identi	fication n	Employer identification number (EIN)	Z	
12 Street address (including room or suite no.)		13 City or town		14	State		200		Ž,		and Zit	D or foreign	n postal	2	
77 GEARY ST STE 400		SAN FRANCISCO			CA CA	Di Collino					1		4108		
Part III Issuer or Other Coverage Provider (see instructions)	Provider (see ins	tructions)								100	3			7.7	
16 Name				17	Employe	r identific	ation nun	Employer identification number (EIN)	18	0-45	Contact telephone number	one numb	er		
BLUE CROSS OF CALIFORNIA					95-3760980	80				1-(800)-888-8288	88-8288				
19 Street address (including room or suite no.)		20 City or town		21	State or province	province			13		y and ZII	P or foreign	Country and ZIP or foreign postal code	code	
120 VIRGINIA AVE		INDIANAPOLIS			Z				1 1	46204-4903	03		9		
(a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered TIN is not available) All 12 months	(b) SSN or other TIN	N (c) DOB (if SSN or other (d) Covered TIN is not available) all 12 months	r (d) Covered all 12 months					(e)	Months o	(e) Months of coverage	· O				
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
RAHUL DUMPALA	*****3189														
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or Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	t Notice, see separat	e instructions.				Cat	Cat. No. 607048	048					Form	1095-	Form 1095-B (2022)