2022 Form MA 1	099-H	C Indi	ividual	Manda	te —	Massac	husetts	Health	Care	Covera	age			
1 Name of Insurance company or administrator Blue Cross Blue Shield of Massachusetts								2 FID number of Insurance co. or administrator 04-1045815						
SAI SURYA MOUNI DANDYALA 11-14-1995								9624151150000						
93 PRESIDENTIAL DR UNIT 2 7 Gity/Town QUINCY										8 State 9 Zip 02169				
Full-year minimum creditable co	overage?	If No, check	months with Mar.	h minimum Apr	creditable Ma	and a	July	Aug.	Sept.	Oct.	Nov.	Dec.	Corrected	
a. Name of dependent Date of birth							Subscriber number							
Full-year minimum creditable co			-				-	-	-	-			Corrected	
l les No	∐ Jan.	Feb.	Mar.	П Арт.	☐ Ma	y June	July	Aug.	Sept.	Oct.	Nov.	Dec.		
b. Name of dependent	dent Date of birth				of birth	Subscriber number								
Full-year minimum creditable of	overage?	If No, check	months wit	h minimuu	craditable	COVERNO						2.50		
Yes No	☐ Jan.	Feb.	Mar.	Apr	Ma Ma	-	July	Aug.	Sept.	Oct.	□ Nov.	Dec.	Corrected	
c. Name of dependent	Date of birth				of birth	Subscriber number								
Full-year minimum creditable co		If No, check					Lines and	C HU UNG	NY MA		a pertur 1	day 7	Corrected	
Yes No	☐ Jan.	Feb.	∐ Mar.	Apr	∐ May	y June	July	Aug.	Sept.	Oct.	Nov.	Dec.		
d. Name of dependent	lame of dependent Date of birth				of birth	Subscribe	r number	garnet I	Surre	755W II	ug B			
Full-year minimum creditable co		If No, check	months will	h minimum	reditable	coverage:							Corrected	
Yes No	☐ Jan.	∐ Feb	Mar.	Apr	May	y June	July	Aug.	Sept.	Oct.	Nov.	Dec.		
e. Name of dependent		Sail loss	fen stel	ni ip ci	Date o	of birth	Subscriber number				China di	PACULT.		
Full-year minimum creditable co	verage?	If No, check	months with	h minimum	reditable							RANGE OF	Corrected	
Yes No		Feb.	Mar.		May	The state of the s	July	Aug.	Sept.	Oct.	Nov.	Dec.	Corrected	
f. Name of dependent	of dependent Date of birth						Subscriber number							
Full-year minimum creditable co		If No, check		-	_	The second second			d insett			Name of the last	Corrected	
Yes No	∐ Jan.	Feb	Mar	Apr.	☐ Ma	y U June	☐ July	L Aug	Sept.	Oct.	Nov.	Dec.		
g. Name of dependent		n Monta	of and	and seed	Date o	of birth	Subscribe	r number	dentado	or happ	70n ab	No.Y		
Full-year minimum creditable co		If No, check	_	-	_			narrain	d glas as	nimah damah	an tared	will.	Corrected	
nestance afromasaira.	∐ Jan.	∐Feb.	∐ Mar.	∐ Apr.	∐ May	/ UJune	July	∐ Aug.	Sept.	Oct.	Nov.	Dec.		
h. Name of dependent						of birth	Subscribe			DATE DE	rai olima seldeno	b is		
Full-year minimum creditable co	overage?	If No, check	months with	_	reditable	_	July	Aug.	Sept.	Пос	□ Nov.	Dec.	Corrected	
				100 00000									The Later	