

KARTHEEK JAMPULA 7 OCEAN VIEW DR APT 709 BOSTON MA 02125-3545

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Form MA 1099-HC Ind	ividual Ma	ndate-Massachus	setts Health Care Coverage 2. FID number of insurance co. or	administrator
1. Name of insurance company of	or administrate	or	2. FID humber of magranes of or	Print to the
BLUE CROSS AND BLUE	SHIELD	OF TX	361236610 5. Subscriber number	
3. Name of subscriber		4. Date of birth	5. Subscriber number	
KARTHEEK JAMPUL	Α.	1993-10-11	000808386625 8. State	9. Zip
6. Street address	ALTERNATION OF THE PARTY OF THE	7. City/Town	8. State	7. Zip
7 OCEAN VIEW DR		BOSTON	MA	021253545
Full-year minimum creditable cov	verage? If No	, check months with m	ninimum creditable coverage:	Corrected
☐ Yes ☒ No			Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐	Sept. 🛮 Oct. 🖾 Nov. 🖾 Dec.
a. Name of dependent	Maria de la compansión de	Date of birth	Subscriber number	riginist tall 1 sati 1 see. Van son saat fant 's bri
Full-year minimum creditable cov	verage? If No.	, check months with m	ninimum creditable coverage:	Corrected:
☐ Yes ☐ No			Apr.□ May □June□ July□ Aug. □ S	Sept. Oct. Nov. Dec.
b. Name of dependent		Date of birth	Subscriber number	
Full-year minimum creditable cov	verage? If No.	, check months with m	inimum creditable coverage:	Corrected:
☐ Yes ☐ No	☐ Jan	. Feb. Mar	Apr.□ May □June□ July□ Aug. □ S	Sept. Oct. Nov. Dec.
c. Name of dependent		Date of birth	Subscriber number	
Full-year minimum creditable cov	erage? If No,	check months with m	inimum creditable coverage:	Corrected:
☐ Yes ☐ No	☐ Jan.	. Feb. Mar. A	Apr.□ May □June□ July□ Aug. □ S	Sept. □Oct. □Nov.□ Dec.
d. Name of dependent	associate a	Date of birth	Subscriber number	
Full-year minimum creditable cov	erage? If No,	check months with m	inimum creditable coverage:	Corrected
yes □ No	☐ Jan.	□Feb. □ Mar. □ A	Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ S	Sept. Oct. Nov. Dec.
e. Name of dependent	rythadd No	Date of birth	Subscriber number	ren mineri peri Militari di Liveri
Full-year minimum creditable cove	erage? If No,	check months with mi	inimum creditable coverage:	Corrected
Yes No	☐ Jan.	□Feb. □ Mar. □ A	Apr. May. June July Aug.	Sept. Oct. Nov. Dec.
Name of dependent		Date of birth	Subscriber number	

2022 Form MA 1099-HC Individual Mandate — Massach 1 Name of Insurance company or administrator Blue Cross Blue Shield of Massachusetts								2 FID number of Insurance co. or administrator 04-1045815						
KARTHEEK JAMPULA	A			10-11-	-1993	1 1 1 1 1	96235	5856300	000					
6 Street address 7 OCEAN VIEW DRIVE 709					7 City/Town BOSTON						8 State 9 Zip 02125			
Full-year minimum creditable	coverage?	If No, check	months wit		creditable May		July	Aug.	Sept.	Oct.	Nov.	Dec.	Corrected	
a. Name of dependent					Date o	f birth	Subscribe	r number		7.9				
Full-year minimum creditable	coverage?	If No, check	months wit								п.,	По	Corrected	
Yes No	Jan.	Feb.	∐ Mar.	☐ Apr.	∐ May	June	July	Aug.	Sept.	∐ Oct.	∐ Nov.	Dec.		
b. Name of dependent		ge pro			Date o	f birth	Subscribe	r number						
Full-year minimum creditable	coverage?							П.	П.,	Пол	Пи	∏ Dec.	Corrected	
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c. Name of dependent					Date o	f birth	Subscribe	r number						
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d. Name of dependent					Date of	f birth	Subscriber	r number						
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e. Name of dependent					Date of	f birth	Subscriber	number						
Full-year minimum creditable	coverage?	If No, check	months wit	h minimum o	creditable		☐ July	∏ Aug.	∏ Sept.	Oct.	∏Nov.	☐ Dec.	Corrected:	
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f. Name of dependent					Date of	f birth	Subscriber	number						
Full-year minimum creditable	coverage?	If No, check	months wit		creditable o		July	Aug.	Sept.	Пос	∏ Nov.	☐ Dec.	Corrected	
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g. Name of dependent					Date of	f birth	Subscriber	number						
Full-year minimum creditable		If No, check			_		п.,	П	По	По	П.,	По	Corrected:	
Yes No	∐ Jan.	Пгев.	∐ Mar.	Apr.	∐ May		∐ July	Aug.	Sept.	ЦОст.	Nov.	Dec.		
h. Name of dependent					Date of	birth	Subscriber	rnumber						
Full-year minimum creditable of	coverage?	If No, check	months with	h minimum c	reditable o	coverage;						3	Corrected:	