Form 1095-B

Health	Coverage
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Do not attach to your tax return. Keep for your records.

CORRECTED

VOID

OMB. No. 1545-2252

Department of the Treasury Internal Revenue Service

Go to www.irs.gov/Form1095B for instructions and the latest information.

Part I Responsible Individual					Parial ago	usitu num	bor (SSN)	or other	TIN 3	B Date of	birth (if S	SN or oth	er TIN is r	not availal	ble)	
1 Name of responsible individual - First name, middle name, last name					2 Social security number (SSN) or other TIN						Dirtir (ii O	01101011				
BHUSHAN JAMISETTI					XXX-XX-0517 6 State or province					7 Country	and ZIP	or foreign	postal co	de		
4 Street address (including apartment no.) 5 City or town			o State of province						7 Country and ZIP or foreign postal code							
9236 STREAM VIEW LANE LAUREL				MD US 20723												
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):				9 Reserved												
Part II Information About Certain				-									Mark to the first of the first second			
10 Employer name									1	11 Employer identification number (EIN)						
MindFinders, Inc.											XX-XXX3447					
2 Street address (including room or suite no.) 13 City or town			14 State or province					1	15 Country and ZIP or foreign postal code							
1200 18TH STREET NW, STE 650	200 18TH STREET NW. STE 650 WASHINGTON			DC						US 20036						
Part III Issuer or Other Coverage P	rovider (see instruc	tions)														
6 Name				17 Employer identification number (EIN)					1	18 Contact telephone number						
CareFirst BlueChoice, Inc.					52-1358219											
19 Street address (including room or suite no.) 20 City or town				21	21 State or province 22 Country and ZIP or foreign postal cod								iue			
				710 00005												
840 First Street, NE Washington Part IV Covered Individuals (Enter the information for each covered individual.)					DC US 20065											
Part IV Covered Individuals (Enter	the information for o	each covered II	1													
(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (If SSN or other TIN 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	
			X						П		П			П		
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23 JAMISETTI	XXX-XX-0517														_	
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