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Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ **Do not attach to your tax return. Keep for your records.**

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2022

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)
Nagaraj Bejugama		766-94-6803	
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
43 Nabnasset St	Westford	MA	01886
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . ▶ D		**9** Reserved	

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

10 Employer name			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

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
WellSense Health Plan		04-3373331	7742926741
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
529 Main Street Suite 500	Charlestown	MA	02129

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	June	July	Aug	Sept	Oct	Nov	Dec
23	Nagaraj Bejugama	766-94-6803		X												
24	NIRUPAMA KASALA	767-96-6111		X												
25	SIDDHIKSHA BEJUGAMA	797-21-5725			X											
26	SHREENIKA BEJUGAMA	755-94-0819			X											
27																
28																