AETNA LIFE INSURANCE COMPANY
PO Box 981206
El Paso, TX 79998

02/07/2019
For more information on the Affordable Care Act or the Individual
Shared Responsibility Provision, visit IRS.gov
More questions? Contact Member Services at the number in Box 18.

GANESHKUMAR DORAISAMY
13836 JEFFERSON PARK DRIV
APT 9304
HERNDON, VA 20171



# Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that the individuals in your tax family (yourself, spouse, and dependents) had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.*

**TIP** *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families* or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

**Part I. Responsible Individual, lines 1-9.** Part I reports information about you and the coverage.

**Lines 2 and 3.** Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable, to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

**! CAUTION** *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

**Line 8.** This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

**A.** Small Business Health Options Program (SHOP)
**B.** Employer-sponsored coverage
**C.** Government-sponsored program
**D.** Individual market insurance
**E.** Multiemployer plan
**F.** Other designated minimum essential coverage

**TIP** *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10-15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part also may be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**Part III. Issuer or Other Coverage Provider, lines 16-22.** This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

**Part IV. Covered Individuals, lines 23-28.** This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if the SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**

Department of the Treasury
Internal Revenue Service

REISSUED STATEMENT

# 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

2018

## Part I Responsible Individual

Tracking #: 12311399T5

| 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) |
|---|---|---|---|
| GANESHKUMAR DORAISAMY | | XXX-XX-0509 | |
| **4** Street address (including apartment no.) | **5** City or town | **6** State or province | **7** Country and ZIP or foreign postal code |
| 13836 JEFFERSON PARK DRIV<br>APT 9304 | HERNDON | VA | US 20171 |

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . . . . . ▶ B

9 Reserved

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

| 10 Employer name | | | 11 Employer identification number (EIN) |
|---|---|---|---|
| (TAIC) TATA AMERICAN INTERNATIONAL CORPO RATION | | | XX-XXX5758 |
| **12** Street address (including room or suite no.) | **13** City or town | **14** State or province | **15** Country and ZIP or foreign postal code |
| 3010 L.B.J. FREEWAY, SUITE 400 | DALLAS | TX | US 75234 |

## Part III Issuer or Other Coverage Provider (see instructions)

| 16 Name | | 17 Employer identification number (EIN) | 18 Contact telephone number |
|---|---|---|---|
| Aetna Life Insurance Company | | 06-6033492 | 855-531-6837 |
| **19** Street address (including room or suite no.) | **20** City or town | **21** State or province | **22** Country and ZIP or foreign postal code |
| PO Box 981206 | El Paso | TX | US 79998 |

## 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 | GANESHKUMAR DORAISAMY | XXX-XX-0509 | | X | | | | | | | | | | | | |
| 24 | RASHEEDA GANESHKUMAR | | 1976-12-20 | X | | | | | | | | | | | | |
| 25 | AASHISH GANESHKUMAR | | 2003-01-15 | X | | | | | | | | | | | | |
| 26 | AADHISH GANESHKUMAR | | 2010-09-11 | X | | | | | | | | | | | | |
| 27 | | | | | | | | | | | | | | | | |
| 28 | | | | | | | | | | | | | | | | |

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ:: (Amharic)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، اپنے شناختی کارڈ پر درج نمبرپر بات کریں۔ (Urdu)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Для получения бесплатной помощи переводчика позвоните по телефону, указанному на Вашей личной карточке медицинского страхования. (Russian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिये नम्बर पर कॉल करें। (Hindi)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ nọmba no na kaadị ID gị. (Ibo)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́ɔ̀ń nì pídyi ní, nìí, ɖá nɔ̀ɓà nìà nì ID káàɔ̀ kɔ̃ɛ. (Kru-Bassa)

Lati wọnú awọn isẹ̀ èdè  l'ọfẹ fun ọ, pe nọmba ori káàdi idánimọ rẹ. (Yoruba)

8A1336.0002

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.