FORM 1099-INT, INTEREST INCOME PAGE 1
FOR TAX YEAR 2017 OMB NO. 1545-0112
01/18/2018

PAYER:
BMO HARRIS BANK N.A.
111 WEST MONROE STREET
CHICAGO IL 60603

021913

PAYER'S FEDERAL EIN:
36-2085229
TELEPHONE:
1-888-340-BANK

RECIPIENT:
KALAMATA RAJASEKHAR
1231 GARDEN STREET
SANTA BARBARA CA 93101

RECIPIENT'S
IDENTIFYING NUMBER:
XXX-XX-5317

NOTE: This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.

ACCOUNT TYPE / CUSIP NUMBER	ACCOUNT NUMBER	BOX 1/ BOX 5/ BOX 10	BOX 2/ BOX 6/ BOX 11	BOX 3/ BOX 8/ BOX 12	BOX 4/ BOX 9/ BOX 13
BANK PROMOTION	XXXXXX0224	300.00	0.00	0.00	0.00
		0.00	0.00	0.00	0.00
		0.00	0.00	0.00	0.00

TOTALS: (The following TOTALS are being furnished to the IRS.)

Box 1 - Interest Income	$	300.00
Box 2 - Early withdrawal penalty	$	0.00
Box 3 - Interest: U.S. Savings Bonds and Treasury Obligations	$	0.00
Box 4 - Federal Income tax withheld	$	0.00
Box 5 - Investment expenses	$	0.00
Box 6 - Foreign tax paid	$	0.00
Box 7 - Foreign country or U.S. possession		
Box 8 - Tax-exempt interest	$	0.00
Box 9 - Specified private activity bond interest	$	0.00
Box 10 - Market discount	$	0.00
Box 11 - Bond premium	$	0.00
Box 12 - Bond premium on Treasury obligations		0.00
Box 13 - Bond premium on tax-exempt bond		0.00
Box 14 - Tax-exempt and tax credit bond CUSIP no.		
Box 15 - State		
Box 16 - State Identification number		
Box 17 - State tax withheld		

---------- COPY B, FOR RECIPIENT ----------

DEPARTMENT OF TREASURY - INTERNAL REVENUE SERVICE

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

560116

OMB No. 1545-2252

2017

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
RAJASEKHAR KALAMATA		***-**-5317	
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
1231 GARDEN STREET	SANTA BARBARA	CA	UNITED STATES 93101
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)
IMPACT RADIUS INC			26-1120226
12 Street address (including room or suite no.)	**13** City or town	**14** State or province	**15** Country and ZIP or foreign postal code
223 EAST DE LA GUERRA ST	SANTA BARBARA	CA	93101

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
UnitedHealthcare, Inc.		41-1922511	866-633-2446
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
601 Brooker Creek Blvd	Oldsmar	FL	UNITED STATES 34677

Part IV Covered Individuals (Enter the information for each covered individual.)

(a) Name of covered individual(s)	(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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 RAJASEKHAR KALAMATA	***-**-5317		☐	☐	☐	☐	☐	☐	☐	☐	☐	X	X	X	X