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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

2019

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)
DATTATRAY		JADHAV	***-**-8711	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
4845 BRIDGE LN APT 8	MASON	OH	45040-7916

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

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
CIGNA FEDERAL BENEFITS, INC.	621724116	1 855 334 7400

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
900 COTTAGE GROVE ROAD	BLOOMFIELD	CT	06002

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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	DATTATRAY		JADHAV	***-**-8711		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	SANDHYA		JADHAV	***-**-0011		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25	TEJAL		JADHAV	***-**-0011		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26	TANVI		JADHAV	***-**-0011		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27																		
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