KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
P.O. Box 629028
El Dorado Hills, CA 95762-9028

Kamalakannan Sanjeevi
18223 LOST KNIFE CIR APT 204
GAITHERSBURG, MD 20886-4221

Your IRS 1095-B Health Coverage Statement for 2017

Secure and convenient, access your 1095-B online!

Sign up at kp.org/paperless1095B

January 18, 2018

Dear Kamalakannan Sanjeevi,

The Affordable Care Act (ACA) requires taxpayers to prove they had health coverage in 2017 when they file their taxes for 2017. The enclosed IRS Form 1095-B reports proof of coverage. We are required to send you this form because you have a health plan with Kaiser Permanente.

What this form does and how you can use it:
This form serves to report proof that you and anyone you enrolled as a dependent on your Kaiser Permanente plan had a basic level of health coverage for the specific dates in 2017. This form only relates to health coverage you have through Kaiser Permanente.
The 1095-B form lists individuals in your family who were enrolled in your coverage and shows their months of coverage. Use this information to help complete your tax return. You do not need to attach these forms to your tax return. For specific questions about your tax situation, please talk to your tax preparer.

Questions?
If you believe there's an error on your form or if you have any questions, please call us at **1-844-477-0450** (TTY **711** for the deaf, hard of hearing, or speech impaired), Monday through Friday, from 8 a.m. to 6 p.m., and Saturday and Sunday (Pacific time), from 7 a.m. to 3 p.m. Or you can go to **kp.org/proofofcoverage** for more information. We're here to help you.

Sincerely,
Kaiser Permanente

This is important information from Kaiser Permanente. If you need help understanding this information, please call Member Services and ask for language assistance.

Services covered under your Kaiser Permanente health plan are provided and/or arranged by Kaiser Permanente health plans: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232.

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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

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)
Kamalakannan Sanjeevi		*****-**-2520**	
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
18223 LOST KNIFE CIR APT 204	**GAITHERSBURG**	**MD**	**UNITED STATES 20886**

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
Kaiser Foundation Health Plan of the Mid-Atlantic States		**520954463**	**844-477-0450**
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
One Kaiser Plaza 15L	**Oakland**	**CA**	**United States of America US 94612**

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
23 **KAMALAKANNAN SANJEEVI**	*****-**-2520**		☐	☐	X	X	X	X	X	X	X	X	X	X	X
24 **GAYATHRI KAMALAKANNAN**	*****-**-8045**		☐	☐	☐	☐	☐	☐	☐	X	X	X	X	X	X
25			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as 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.