

Form MA 1099-HC Individual Mandate — Massachusetts Health Care Coverage

1 Name of Insurance company or administrator Blue Cross Blue Shield of Massachusetts		2 FID number of Insurance co. or administrator 04-1045815		
3 Name of subscriber		4 Date of birth		5 Subscriber number
6 Street address		7 City/Town		8 State
9 Zip				

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

a. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

b. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

c. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

d. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

e. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

f. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

g. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

h. Name of dependent _____ Date of birth _____ Subscriber number _____

Full-year minimum creditable coverage? Yes No If No, check months with minimum creditable coverage:
 Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. Corrected:

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