Form MA 1099-HC	IIIU	ividuai iv	nanuale	<u> — IVI</u>	assac	<u>husetts</u>	<u>Health</u>	Care C	<i>J</i> overa <u>c</u>	je			
1 Name of Insurance company or administrator							2 FID number of Insurance co. or administrator						
Blue Cross Blue Shie	ısetts				04-1045815								
3 Name of subscriber				4 Date of birth			5 Subscriber number						
6 Street address						7 City/Town				8 State	9 Zip		
O Officer address						7 Oity/ Fown				Colaic	Jo Zip		
Full-year minimum creditable cov	erage? ∏Jan.	If No, check	months with Mar.	n minimum o	creditable May		July	Aug.	Sept.	Oct.	Nov.	Dec.	Corrected:
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a. Name of dependent				Date of birth			Subscriber number						
Full-year minimum creditable cov	erage?	If No, check	months with	n minimum o	creditable	coverage:							Corrected:
Yes No	∐Jan.	_	☐ Mar.	Apr.	☐ May		July	Aug.	Sept.	Oct.	Nov.	Dec.	
b. Name of dependent					Date o	f birth	Subscribe	r number					
Full-year minimum creditable cov	erage?	If No, check	months with	minimum o	creditable	coverage:							Corrected:
Yes No	☐ Jan.	Feb.	☐ Mar.	Apr.	☐ May	June	UJuly	Aug.	Sept.	Oct.	Nov.	Dec.	
					_								
c. Name of dependent					Date o	f birth	Subscribe	r number					
Full-year minimum creditable cov	erage?	If No, check	months with	n minimum (creditable	coverage:							Corrected:
Yes No	☐ Jan.	Feb.	☐ Mar.	Apr.	☐ May	June	UJuly	Aug.	Sept.	Oct.	Nov.	Dec.	
d. Name of dependent					Date o	f birth	Subscribe	r number					
d. Name of dependent					Date o	f birth	Subscribe	r number					
d. Name of dependent Full-year minimum creditable cov	erage?	If No, check	months with	n minimum (Subscribe	r number					Corrected:
·	erage?	_	months with	n minimum o		coverage:	Subscribe	r number	Sept.	□Oct.	Nov.	Dec.	Corrected:
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