

Form MA 1099-HC Individual Mandate Massachusetts Health Care Coverage

1. Name of insurance company or administrator									2. FID number of insurance co. or administrator				
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?	If No, indicate months with minimum creditable coverage:												Corrected:
○Yes ○No	🔾 Jan.	O Feb.	⊖ Mar.	⊖ Apr.	O May.	⊖ June	⊖ July	O Aug.	O Sept.	O Oct.	O Nov.	O Dec.	
a. Name of dependent	Date of birth Subscriber number												
Full-year minimum creditable coverage?	If No, indicate months with minimum creditable coverage:											Corrected:	
○Yes ○No	🔾 Jan.	O Feb.	⊖ Mar.	⊖ Apr.	O May.	() June	⊖ July	O Aug.	O Sept.	O Oct.	O Nov.	O Dec.	
b. Name of dependent	Date of birth				Subscriber number								
Full-year minimum creditable coverage?	If No, indicate months with minimum creditable coverage:											Corrected:	
⊖Yes ⊖No	🔾 Jan.	O Feb.	⊖ Mar.	⊖ Apr.	O May.	⊖ June	⊖ July	OAug.	O Sept.	O Oct.	⊖ Nov.	O Dec.	
c. Name of dependent		[Date of bir	rth	Subscriber number								
Full-year minimum creditable coverage?	If No, indicate months with minimum creditable coverage:											Corrected:	
⊖Yes ⊖No	🔿 Jan.	O Feb.	⊖ Mar.	⊖ Apr.	O May.	⊖ June	⊖ July	O Aug.	O Sept.	O Oct.	O Nov.	O Dec.	
d. Name of dependent		[Date of bir	rth	Subscriber number								
Full-year minimum creditable coverage?	If No, indicate months with minimum creditable coverage:												Corrected:
○ Yes ○ No	⊖ Jan.	O Feb.	O Mar.	⊖ Apr.	O May.	⊖ June	⊖ July	⊖ Aug.	O Sept.	O Oct.	O Nov.	O Dec.	