Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2025

Massachusetts Department of Revenue

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? ◯ Yes ◯ No

If No, indicate 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, indicate 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, indicate 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, indicate 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, indicate months with minimum creditable coverage: ◯ Jan. ◯ Feb. ◯ Mar. ◯ Apr. ◯ May. ◯ June ◯ July ◯ Aug. ◯ Sept. ◯ Oct. ◯ Nov. ◯ Dec.

Corrected: