### Form MA 1099-HC
**Individual Mandate**
**Massachusetts Health Care Coverage**

<table>
<thead>
<tr>
<th>1. Name of insurance company or administrator</th>
<th>2. FID number of insurance co. or administrator</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>3. Name of subscriber</td>
<td>4. Date of birth</td>
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<tr>
<td></td>
<td>5. Subscriber number</td>
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<tr>
<td>6. Street address</td>
<td>7. City/Town</td>
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<td></td>
<td>8. State</td>
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<td></td>
<td>9. Zip</td>
</tr>
</tbody>
</table>

**Full-year minimum creditable coverage?** If No, check months with minimum creditable coverage: Corrected:
- Yes ☐  No ☐

#### a. Name of dependent
- Date of birth
- Subscriber number

**Full-year minimum creditable coverage?** If No, check months with minimum creditable coverage: Corrected:
- Yes ☐  No ☐

#### b. Name of dependent
- Date of birth
- Subscriber number

**Full-year minimum creditable coverage?** If No, check months with minimum creditable coverage: Corrected:
- Yes ☐  No ☐

#### c. Name of dependent
- Date of birth
- Subscriber number

**Full-year minimum creditable coverage?** If No, check months with minimum creditable coverage: Corrected:
- Yes ☐  No ☐

#### d. Name of dependent
- Date of birth
- Subscriber number

**Full-year minimum creditable coverage?** If No, check months with minimum creditable coverage: Corrected:
- Yes ☐  No ☐