Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2008

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 coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

a. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

b. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

c. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

d. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected: