BLUE CROSS BLUE SHIELD OF MASS
HMO BLUE INC.
101 HUNTINGTON AVENUE, SUITE 1300
BOSTON, MA 02199-7611

01/19/2018
IF YOU HAVE QUESTIONS OR FOR MORE INFORMATION:
VISIT WWW.BLUECROSSMA.COM/TAXINFORMATION OR
CONTACT BLUE CROSS BLUE SHIELD OF
MASSACHUSETTS AT 1-888-407-5719
PLEASE HAVE YOUR INDENTIFICATION NUMBER READY

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AWAIS SULTAN
1157 W VERNON PARK PL
CHICAGO, IL 60607

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.*

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.*

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families* or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

Part I. Responsible Individual, lines 1-9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.

! CAUTION *If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Other designated minimum essential coverage

TIP *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange) that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals.

Line 9. Reserved.

Part II. Information about Certain Employer-Sponsored Coverage, lines 10-15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

Part III. Issuer or Other Coverage Provider, lines 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). **Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.**

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN or other TIN isn't entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ **Do not attach to your tax return. Keep for your records.**

▶ **Go to *www.irs.gov/Form1095B* for instructions and the latest information.**

☐ VOID

☐ CORRECTED

OMB. No. 1545-2252

2017

Part I Responsible Individual

1 Name of responsible individual	2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
AWAIS SULTAN	XXX-XX-6504	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
1157 W VERNON PARK PL	CHICAGO	IL	US 60607

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . ▶ B

9 Reserved

Part II Information About Certain Employer-Sponsored Coverage (see instructions)

10 Employer name	11 Employer identification number (EIN)
TECHLOGIX INC.	XX-XXX0314

12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code
400 TRADE CENTER SUITE 4900	WOBURN	MA	US 01801

Part III Issuer or Other Coverage Provider (see instructions)

16 Name	17 Employer identification number (EIN)	18 Contact telephone number
BLUE CROSS BLUE SHIELD OF MASS HMO BLUE INC.	04-3362283	1-888-407-5719

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
101 HUNTINGTON AVENUE, SUITE 1300	BOSTON	MA	US 02199-7611

Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
23	AWAIS SULTAN	XXX-XX-6504		☐	X	X	X	X	X	X	X	X	X	☐	☐	☐
24	SALIHA AWAIS		1983-04-21	☐	X	X	X	X	X	X	X	X	X	☐	☐	☐
25	MEKAEL J SULTAN		2010-09-20	☐	X	X	X	X	X	X	X	X	X	☐	☐	☐
26	DANIA A SULTAN		2012-01-22	☐	X	X	X	X	X	X	X	X	X	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐