

## COMPLETE SCHEDULE HC-CS TO REPORT ADDITIONAL INSURANCE COMPANIES

| IRST NAME   | M.I. LAST NAME                           |                |                 |             |              |           |         |       |       | SOCIAL SECURITY NUMBER |      |      |       |        |       |        |        |         |
|---|--|----------------|-----------------|-------------|--------------|-----------|---------|-------|-------|------------------------|------|------|-------|--------|-------|--------|--------|---------|
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| Schedule HC-C   | S Health Care                            | e Info         | orma            | atio        | n Co         | onti      | nu      | atic  | n S   | Sh                     | ee   | t    |       |        |       |        | 21     | 023     |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| Complete Schedule HC-CS, Health C   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| nore than two private health insurand<br>ut the information below, using Forr |  |                |                 |             |              |           |         |       |       | ortea                  | on S | cnec | ule F | IC, II | ne(s) | 4f and | /or 4g | j. FIII |
| at the information below, using For   | THINA 1033 FIG, to report the            | G IIIIOIIII    | 2011 11011      | ii youi a   | uuitiona     | i iiisuii | u1100 C | σπραι | 1103. |                        |      |      |       |        |       |        |        |         |
| PART A. YOUR HEALTH INSURA  | INCE                                     |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF THIRD INSURANCE COMPANY OR ADMIN                                      | NISTRATOR IF NECESSARY (from box 1 of    | f Form MA 10   | 099-HC)         |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| EDERAL IDENTIFICATION NUMBER OF INSURANCE O                                   | CO. (from box 2 of Form MA 1099-HC)      | SUBSCRI        | IBER NUMBE      | R (from For | m MA 1099-   | HC)       |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF FOURTH INSURANCE COMPANY OR ADD                                       | MINISTRATOR IF NECESSARY (from box 1     | of Form MA     | 1000_HC)        |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF FOOTH INSOLINGE COMPANY OF ADM  | WINIOTHATOTT IN NEOLOGARTI (IIOIII BOX T | OTT OTT INIA   | 1033 110)       |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| EDERAL IDENTIFICATION NUMBER OF INSURANCE O                                   | CO. (from box 2 of Form MA 1099-HC)      | SUBSCRI        | IBER NUMBE      | R (from For | m MA 1099-   | HC)       |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| PART B. SPOUSE'S HEALTH INS   |  |                |                 |             | insurand     | e plan)   |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF THIRD INSURANCE COMPANY OR ADMIN                                      | NISTRATOR IF NECESSARY FOR SPOUSE        | (from box 1    | of Form MA 1    | 1099-HC)    |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| EDERAL IDENTIFICATION NUMBER OF INSURANCE O                                   | CO. (from box 2 of Form MA 1099-HC)      | SPOUSE'        | S SUBSCRIBI     | er numbei   | R (from Form | MA 1099   | 9-HC)   |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF FOURTH INCURANCE COMPANY OR ADA                                       | MINIETDATAD IF NEGEGRADY FOR COOLIG      | OF // b        | 4 -4 F Mi       | A 4000 IIO  |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| NAME OF FOURTH INSURANCE COMPANY OR ADIV                                      | MINISTRATOR IF NECESSARY FOR SPOUS       | SE (ITOITI DOX | I OI FOITH IVI/ | A 1099-HC)  |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |
| EDERAL IDENTIFICATION NUMBER OF INSURANCE O                                   | CO. (from box 2 of Form MA 1099-HC)      | SPOUSE'        | S SUBSCRIB      | er number   | R (from Form | MA 1099   | 9-HC)   |       |       |                        |      |      |       |        |       |        |        |         |
|   |  |                |                 |             |              |           |         |       |       |                        |      |      |       |        |       |        |        |         |