

Tax Year 2019 / Processing Year 2020

Predefined Scenario

Submission 1 Narratives – (Test Scenarios 1-0, 1-1, 1-2)

Instructions: Prepare a transmission using the Tax Year 2019 1094-B and 1095-B Forms for a provider of health coverage. In this scenario, Hidetestone is the provider who will be reporting health coverage information for two responsible individuals.

1094-B Submission Narrative Information

Scenario 1-0

Filer's Name: Hidetestone

Employer Identification Number (EIN): 00-0000151

Name of person to contact: Bertha Logan

Contact telephone number: 5551352468

Address: 975 Adler Lane Suite 312

City: New York

State or province: NY

Country and ZIP or foreign postal code: 10023

Total number of Forms 1095-B submitted with this transmittal: 2

Signature, title and date can be left blank, as there is no requirement for these elements within TY2019.

1095-B Record Narrative Information

Scenario 1-1 Responsible Individual #1

Part I Responsible Individual

Responsible Individual Name: Hide Nursing Care

Social Security Number (SSN): 00-0000152

Date of Birth (if no SSN available): not applicable for this scenario

Address: 4435 Chestnut Avenue

City: Madison

State: NC

Country and ZIP or foreign postal code: 27025

Enter letter identifying Origin of the Health Coverage: D – Individual Market Insurance

Part II Information about Certain Employer-Sponsored Coverage – no need to complete this section for this scenario

Part III Issuer or Other Coverage Provider

Name: Hidetestone

Employer Identification Number (EIN): 00-0000151

Contact telephone number: 5551352468

Address: 975 Adler Lane Suite 312

City: New York

State or province: NY

Country and ZIP or foreign postal code: 10023

Part IV Covered Individuals

Hanna lives in a nursing care facility and were covered for at least one day per month for “All 12 months” of the calendar year.

Covered Individual: Hanna Martin 000-00-0101

Note: While it is understood that there are two correct ways to complete Part IV, in this AATS Scenario, please select the “Covered all 12 months” check box rather than entering data in each of the 12 monthly check boxes.

Scenario 1-2 Responsible Individual #2

Part I Responsible Individual

Responsible Individual Name: Dolly Martinez

Social Security Number (SSN): not on file

Date of Birth (if no SSN available): 1973-02-06

Address: 1313 Buckthorn Lane

City: Washington

State: DC

Country and ZIP or foreign postal code: 20026

Enter letter identifying Origin of the Health Coverage: D – Individual Market Insurance

Part II Information about Certain Employer-Sponsored Coverage – no need to complete this section for this scenario

Part III Issuer or Other Coverage Provider

Name: Hidetestone

Employer Identification Number (EIN): 00-0000151

Contact telephone number: 5551352468

Address: 975 Adler Lane Suite 312

City: New York

State or province: NY

Country and ZIP or foreign postal code: 10023

Part IV Covered Individuals

Dolly and her spouse were covered for at least one day per month for each month June 1st through December 31st (inclusive).

Responsible Individual: Dolly Martinez 1973-02-06

Spouse: Edward Martinez 000-00-0120

