**Affidavit for Proof of Massachusetts Residency for Health Coverage**

3/1/2017

Applicant’s Full Legal Name

Applicant’s SSN [If applicable]

Applicant’s DOB

Applicant’s member ID [If applicable]

Street Address

City, State, Zip Code

Phone Number

E-mail Address [If applicable]

To Whom It May Concern,

I certify that I, (insert applicant’s full legal name) , live at (street address, city, state, zip code .

I certify that I, ­­­­­­­­­­­­­ (insert applicant’s full legal name) , have lived at this residence for (days, months, and years) beginning on (month/day/year) . Please accept this as proof of my Massachusetts residence for health coverage purposes.

I, (insert applicant’s full legal name) , certify that the above information is true and accurate. I am not visiting Massachusetts for personal pleasure (e.g. vacation) or for the purpose of receiving medical care in a setting other than a nursing facility. I realize that should any of this information be false, I am liable for any penalties which the law provides under criminal or civil codes.

Thank you,

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Applicant Signs Here Applicant’s Name Here  Today’s Date

Fax to 1-857-323-8300;

or

Mail to:

**Health Insurance Processing Center**

P.O. Box 4405

Taunton, MA 02780