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

3/13/2017

Applicant’s Full Legal Name:

Applicant’s SSN [If applicable]:

Applicant’s DOB:

Applicant’s member ID [If applicable]:

Street Address:

Phone Number:

E-mail Address [If applicable]

To Whom It May Concern,

I certify that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, live at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

 I certify that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have lived at this residence for beginning on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please accept this as proof of my Massachusetts residence for health coverage purposes.

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 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,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

 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