MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Sample Member
50 BROADWAY
BOSTON, MA 02116

Date: August 15, 2019
Notice ID: AUTO_REN
Notice Name: Final Renewal Notice
Subscriber Member ID: 000000000000
Reference ID: RefID_1549104666185

It's time to renew your insurance coverage for 2020. If you want to stay enrolled in your current plan, or a similar plan that we've chosen for you, just pay your monthly premium when you get your bill for January coverage. If you've had any changes to your household since you last updated your account, it's important to let us know about these changes at this time. This is so we can be sure you get the right coverage for next year.

You can choose to shop for a new plan during Open Enrollment. The Open Enrollment period starts November 1. You may be able to save money on your health coverage for next year if you shop and compare your options during Open Enrollment.

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What you need to do:

1. Review your information for 2020, including your program eligibility, renewal plan, new monthly premium amount, and monthly tax credit for next year.
2. Compare any changes between your current plan and your plan for 2020 with our online **Plan Compare** tool at: **www.MAhealthconnector.org/compare-plans.**
3. Shop during Open Enrollment. You may be able to save on the cost of your health plan for next year by comparing your available options for 2020. You can view plans for 2020 through your online account at MAhealthconnector.org. If you don't have an online account, you can get help with shopping over the phone by calling Customer Service, or get help in-person at one of our walk-in centers or with an Enrollment Assister.
4. Keep paying your monthly premium bill by the 23rd of every month to stay covered.

Important Dates:

- **November 1, 2019.** First date to start shopping and comparing plans at MAhealthconnector.org.
- **December 23, 2019.** Pay your premium by this date to enroll in the plan you want for January.
- **January 1, 2020.** The first day of your new 2020 coverage. If there have been any changes to your program eligibility, January 1 is the date when those changes will start.

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Health Insurance Renewal Information						
Household Member	**Date of Birth**	**2020 Program Eligibility**	**Current Health Plan Name**	**2020 Renewal Health Plan Name**	**Same plan as 2019?**	**Date Coverage Renews**
Sample Member	May 3, 1980	ConnectorCare Plan Type 2B with Advance Premium Tax Credit	Tufts Health Plan - Direct ConnectorCare	Tufts Health Plan - Direct ConnectorCare	No	January 1, 2020

Your new monthly premium for 2020

2020 Monthly Health Plan Cost: $44.00 (amount you pay each month)

- This is the amount your household will pay each month if you stay enrolled in the 2020 health insurance renewal plan listed above.
- There are other ConnectorCare plans available to you for 2020. You can see all of your ConnectorCare plan options and their monthly premium costs in the "2020 ConnectorCare plans" section of this letter.

Tax credit information for 2020

2020 Maximum Advance Premium Tax Credit amount: $0.00 per month

This is the amount of tax credit that will be used to lower your premium each month for 2020.

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2020 ConnectorCare plans

The following ConnectorCare plans will be available to you in 2020.

2020 ConnectorCare plans Available for: Sample Member	
ConnectorCare plan name	**Your monthly premium**
BMC HealthNet Plan	44.00
Tufts Health Direct ConnectorCare 2	44.00
AllWays Health Partners	267.00

Important things to know about 2020 ConnectorCare plan options:

- All of your benefits and co-payment costs will be the same, no matter which ConnectorCare plan you choose.
- Some of the ConnectorCare plans offered could have lower monthly premiums than your renewal plan for 2020. Make sure to compare premium costs.
- Providers (such as a doctors, hospitals, or health centers) available through your current plan may be changing in 2020. Make sure that any providers you want to be able to use are in the provider network of a plan before you enroll.

Why can't I stay in the same plan for next year?

If your 2020 renewal plan is different than the plan you are currently enrolled in is either because:

- Your current plan will not be available in 2020, or
- You won't qualify for your current plan in 2020

If you can't enroll again into your current plan for 2020, we've chosen a similar plan that you can easily renew into instead. We chose this plan for you because we believe that the benefits will be similar to the plan you're currently enrolled in, with the same insurer (if possible).

However, please make sure to compare the benefits and costs for this plan with your current plan. You can compare these plans with our tool at **www.MAhealthconnector.org/compare-plans** before you decide if you want to stay in this plan. If you don't want to stay in the plan we've chosen for you, you can enroll in a new plan during Open Enrollment.

How did we make this decision about your eligibility?

The people listed on this notice qualify for coverage for the following reasons:

- Sample Member Member ID: 300001339612
  - You are a resident of Massachusetts. 45 C.F.R. §155.305(a)(3)
  - You are a United States citizen or non-citizen who is lawfully present. 45 C.F.R. §155.305(a)(1)

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- Our records indicate that you are not serving a prison sentence. 45 C.F.R. §155.305(a)(2)
- You do not have access to health insurance through another source that meets affordability and minimum essential coverage standards. 45 C.F.R. §155.305(f)(2)
- Our records indicate that your annual household income in 2020 is 180.37% of the Federal Poverty Level. 45 C.F.R. §155.305(f)(2)(B)

If you do not agree with our decision

You may appeal to the Health Connector if you do not agree with our decision about your eligibility for 2020. Please use the ***Hearing Request Form*** that came with this letter.

Please note: you don't need to file an appeal in order to change the information that we have about you. You can make changes to your information through your online account, or by calling Customer Service.

You don't need to file an appeal if you want to change plans for 2020. To change your enrollment, you will need to shop for a new plan during Open Enrollment. Choose a new plan and pay your first premium by December 23 to enroll for January 1.

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If your information changes

Please update your information **within 30 days of any changes**. These include changes such as your address or family size. It is important that you let us know right away if you have a change of address, because we send important notices affecting coverage. If you do not receive those notices because we have an old address, you could risk losing your health or dental coverage.

You must also update your information with any changes to your income or health insurance access. If you don't let us know if this information changes, you could end up owing the IRS money when you file your federal income tax return.

You can update your information through your online account at MAhealthconnector.org, or by calling Customer Service.

If you have questions

If you have questions, you can get help in any of the following ways:

- Online. Go to our website at MAhealthconnector.org to find more information about renewing your coverage.

- In person. There are many places where you can get free, in-person help. You can go to any of the following walk in centers, which are open all year.

  Boston
  133 Portland Street
  Boston, MA 02114

  Springfield
  88 Industry Avenue, Suite D
  Springfield, MA 01104

  Worcester
  146 Main Street
  Worcester, MA 01608

  You can find a list of more locations and their hours at:
  www.MAhealthconnector.org/help-center

- By phone. Call Health Connector Customer Service at 1-877-MA ENROLL (1-877-623-6765) or TTY: 1-877-623-7773.

Thank you,

Massachusetts Health Connector

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Frequently Asked Questions

What if I want to change plans?

The 2020 Open Enrollment period is from November 1, 2019, through January 23, 2020. If you want to change plans for 2020, you will need to make this change during Open Enrollment. For coverage that starts January 1, 2020, you must change your enrollment and pay your first premium by December 23. If you don't want to shop through the Health Connector, you could look at health plans directly from a health insurer. However, if you qualify for help paying for costs, you can only get these savings if you enroll through the Health Connector.

Can I get coverage through MassHealth?

MassHealth will check to see if the people listed on this notice qualify for health coverage through MassHealth, the Health Safety Net (HSN), or Children's Medical Security Plan (CMSP).

MassHealth will send another letter, letting them know if they qualify for any of these programs, and will contact them if they need more information to make a decision. If you have any questions about MassHealth, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

When does my new program eligibility start?

If there are any changes to the type of coverage that you qualify for, those changes will start as of January 1, 2020. You will stay enrolled in your current type of coverage through the end of 2019 unless you let us know that your information for 2019 has changed. If you or anyone in your household now qualifies for MassHealth, those benefits may start sooner.

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Why is my tax credit $0.00?

If your tax credit amount is $0.00, it is because there are good, high-quality plans that are available to you through the Health Connector at an affordable premium, without any extra help. You can learn more about how tax credits are calculated at MAhealthconnector.org.

How can I prevent owing some of my tax credit back to the IRS?

If your income for the year ends up being higher than you estimated on your application, you could end up owing some or all of your tax credit back to the IRS at tax time. The best way to prevent this is to keep your income information in your account as up to date as possible throughout the year.

If your income changes often, you may want to lower the amount of tax credit that is applied to your monthly premiums. By taking less than the full amount that you qualify for, you may help to prevent owing money at tax time. However, this will mean that your monthly premiums will be higher.

You can update your information and change your tax credit amount through your online account at MAhealthconnector.org. If you don't have an online account, please call Customer Service.

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You may use this **Hearing Request Form** to appeal the Health Connector's decision.

Your Right to Appeal
If you disagree with the action taken by the Massachusetts Health Connector, or if no one acted on your request in a reasonable time, you can ask for a hearing before an impartial hearing officer.

How to Appeal
Fill out this form and send it to the **Massachusetts Health Connector Appeals Unit, P.O. Box 960189 Boston, MA 02196** or fax it to **1-617-933-3099**. Keep a copy for your records. We must receive your request 30 days from the date you received the notice of our action. If we did not act on your application, we must receive the request 120 days from the date of the intended action.

Health Coverage During Your Appeal
You may be able to keep your Health Connector plan while your appeal is being decided. If you qualify for this, the Health Connector will notify you.

Date of Hearing
At least 15 days before the hearing, we will send you a notice telling you the date and time of the hearing. Your hearing will be conducted by phone, but you may request an in-person hearing for good cause by calling the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773).

Your Right to Be Helped at the Hearing
You may have a lawyer or other person represent you. We will not pay for a representative. You may contact a local legal aid service or community agency to see if you can receive help or representation at no cost. If someone other than a lawyer is acting on your behalf, please attach a copy of the document authorizing that person (e.g., Power of Attorney, Guardian, or Authorized Representative).

If You Need an Interpreter, Assistive Device, or Other Accommodation at a Hearing
If you don't understand English or are hearing or sight impaired, we will provide an interpreter or assistive device. We may also make other reasonable accommodations a person with a disability needs to attend a hearing. Tell us what you need in the "Other Information" section below.

Your Right to Review Your Case File
You or your representative can review your case file before the hearing. If you wish to review your case file, please call the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773).

Your Right to Ask to Subpoena Witnesses and Your Right to Question
You or your representative may write to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and ask questions of witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members
An appeal decision for one household member may change eligibility for other household members.

Requesting an Expedited Appeal
If you need an expedited appeal in order to avoid serious harm to your health, please call the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773).

Communication Through Email and Voicemail
If you would like to receive communications from us about your appeal through email or voicemail, including personal information about your household, please tell us below. Email may be unsecure, which means that there is some risk that a third party could read or access the email while in transit. If you agree, you can change your mind later by contacting the Health Connector Appeals Unit and telling them you no longer want us to communicate with you through these methods.

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Hearing Request Form

MASSACHUSETTS HEALTH CONNECTOR

Sample Member

Notice ID: AUTO_REN **Notice Date: August 15, 2019**

First Name | Middle Initial | Last Name | Date of Birth

Mailing address | City | State | Zip

Phone number | Email | Member ID

List household members who are appealing:_____

Reason for your appeal (Circle any reason(s) that may apply)
Income | Citizenship/Immigration status | Residency | Family size
Premium Waiver/Reduction | Access to other insurance | Incarceration
Qualifying Event to Enroll | Other:_____

Please explain why you are appealing. Attach supporting documents: _____
_____

Other information Please check all that may apply.
__ I need an interpreter. My language is_____
__ I need an assistive device to communicate at a hearing. (Describe device)_____
_____
__ I need another accommodation for a disability (Describe accommodation)_____
_____

Appeal Representative, if any

First Name | Last Name | Title

Mailing Address | City | State | Zip code | Phone Number

Communication Through Email or Voicemail Please check all that apply.
I agree to receive communications about my appeal, including personal information, through:
___ Email ___ Voicemail or answering machine

Signature The information on this form is true and accurate to my knowledge. I authorize the Health Connector to provide me and my representative or translator with my individual information, including federal and state tax information used to determine my eligibility, for this appeal.

Signature (Sign) | Date | First and Last Name (Print)

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your authorized representative form, power of attorney document, or evidence of court appointment as a personal representative). **180.37%**

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To get this information in English **large print** or **Braille**, call 1-877-623-6765.
TTY: 1-877-623-7773.

Important! This has important information about your health insurance. If you want the information translated into your own language, call **1-877-623-6765**.

¡Importante! Esto tiene información importante sobre su seguro de salud. Si usted quiere la información traducida a su propio idioma, llame al **1-877-623-6765**.

Spanish

សំខាន់!
ក្នុងនេះមានព័ត៌មានសំខាន់អំពីធានារ៉ាប់រងសុខភាពរបស់អ្នក។ ប្រសិនបើអ្នកចង់បានព័ត៌មាននេះបកប្រែជាភាសារបស់អ្នក សូមទូរស័ព្ទមកលេខ**1-877-623-6765**។

Cambodian

重要提示：該文件載有關於您的醫療保險的重要資訊。如果您想要將相關資訊 翻譯為您的母語，請致電 **1-877-623-6765**。

Traditional Chinese

重要提示：该文件载有关于您的医疗保险的重要信息。如果您想要将相关信息翻译为您的母语，请致电**1-877-623-6765**。

Simplified Chinese

Enpòtan! Sa a gen enfòmasyon enpòtan ou asirans sante ou. Si w vle nou tradwi enfòmasyon an nan pwòp lang ou rele **1-877-623-6765**.

Haitian Creole

ສິ່ງສຳຄັນ!
ນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການປະກັນໄພສຸຂະພາບຂອງທ່ານ. ຖ້າຫາກທ່ານຕ້ອງການຂໍ້ມູນຂ່າວສານເຂົ້າໃນການແປພາສາໂທຫາ **1-877-623-6765** ຂອງຕົນເອງຂອງທ່ານ.

Laotian

Importante! Neste pacote há informações importantes sobre o seu seguro-saúde. Se quiser que as informações sejam traduzidas para o seu idioma, ligue para **1-877-623-6765.**

Brazilian Portuguese

Importante! Contém informações importantes sobre o seu seguro de saúde. Se desejar a tradução das informações para a sua língua, contacte-nos pelo telefone **1-877-623-6765**.

European Portuguese

Важная информация! Здесь содержится важная информация о Вашем медицинском страховании. Если Вы хотите, чтобы информация была переведена на Ваш родной язык, позвоните по номеру: **1-877-623-6765**.

Russian

Lưu ý quan trọng! Đây là thông tin quan trọng về bảo hiểm y tế của quý vị. Nếu quý vị muốn có bản dịch thông tin này bằng ngôn ngữ của quý vị, hãy gọi số **1-877-623-6765**.

Vietnamese

هام! يتضمن هذا معلومات مهمة عن تأمينك الصحي.
إذا كنت تريد ترجمة المعلومات إلى لغتك فاتصل برقم **1-877-623-6765**.

Arabic

Important! Ceci contient des informations importantes au sujet de votre assurance santé. Si vous désirez une traduction de ces informations dans votre langue, appelez le : **1-877-623-6765**.

French

Σημαντικό! Το παρόν περιέχει σημαντικές πληροφορίες σχετικά με την ασφάλεια ζωής σας.Εάν επιθυμείτε να μεταφραστούν οι πληροφορίες αυτές στη γλώσσα σας, καλέστε στο **1-877-623-6765**.

Greek

મહત્વપૂર્ણ !આમાં તમારી આરોગ્ય વીમા વિશેની મહત્વપૂર્ણ જાણકારી છે. જો તમારે તમારી ભાષામાં આ જાણકારીનો અનુવાદ જોઇએ તો,

1-877-623-6765 પર કૉલ કરો.

Gujarati

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महत्वपूर्ण! इसमें आपके स्वास्थ्य बीमा के बारे में महत्वपूर्ण जानकारी है। यदि आप अपनी भाषा में इस जानकारी का अनुवाद चाहते हैं, तो **1-877-623-6765** पर कॉल करें।
Hindi

Importante! Questo documento contiene informazioni importanti sulla sua assicurazione sanitaria. Se desidera averne la traduzione nella sua lingua, chiami il numero **1-877-623-6765.**
Italian

중요! 귀하의 건강 보험에 관한 중요한 내용입니다. 해당 내용을 귀하가 사용하는 언어로 번역을 원하시면**1-877-623-6765**로 연락하십시오.
Korean

Ważne! Tutaj zawarte są ważne informacje na temat Państwa ubezpieczenia zdrowotnego. Jeśli chcą Państwo, aby te informacje zostały przetłumaczone na Państwa język, proszę zadzwonić na numer **1-877-623-6765**.
Polish

Discrimination is against the law

The Health Connector complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Connector does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Connector provides free aids and services to people with disabilities to communicate effectively with us. These aids and services include:

- Qualified sign language interpreters
- Written information in other formats like large print, audio, accessible electronic formats, and other formats.

The Health Connector provides free language services to people whose primary language is not English. These services include qualified interpreters and information written in other languages

If you need these services, contact the Massachusetts Health Connector at 1-877-MA-ENROLL (1-877-623-6765) or TTY 1-877-623-7773.

You can file a grievance if you think you have been discriminated against

If you believe that the Health Connector or another party operating on the exchange has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Health Connector or the U.S. Department of Health and Human Service Office for Civil Rights.

If you want to file a grievance with the Health Connector, please visit our website to download our policy and complaint form. You can find these documents online at: www.MAhealthconnector.org/site-policies/nondiscrimination-notice.

If you need help filing a grievance, please email the Health Connector's Compliance Manager at Nondiscrimination@state.ma.us or call 617-936-1037.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. To learn more about filing a complaint, call 1-800-368-1019, 800-537-7697 (TDD) or go to their website at: www.hhs.gov/civil-rights/filing-a-complaint.

Massachusetts Official

Mail-In Agency Voter Registration Form

William Francis Galvin
Secretary of the Commonwealth

How to use this form

1. Confirm your citizenship.
2. Print your name: last name, first name, middle name or initial.
3. Print your former name, if applicable.
4. Print the address where you live now: number and street name or rural route number and box number (do not provide a post office box number), apartment number, city or town and full zip code. Use the map† at right if you cannot otherwise identify your address.
5. Print the address where you receive all your mail, if it is different from the address entered on #4.
6. Print your date of birth: month, day and year. If you are 16 or 17 years old, you will be pre-registered until you are old enough to vote. You will be notified by mail when you become eligible to vote.
7. Federal law requires that you provide your driver's license number to register to vote. If you do not have a current and valid Massachusetts driver's license, you must provide the last four digits of your social security number. If you have neither, you must write "none" in the box.
8. It is optional to provide your telephone number. If you include your telephone number and do not check "unlisted" it will be a public record.
9. Check a party, 'no party' or print a political designation (not a party).
10. Print the address where you were last registered to vote.
11. If a person is helping you because you are physically unable to sign this form, that assisting person must print his or her name and address and has the option to print his or her telephone number.
12. Read the oath.
13. Print today's date.
14. Sign your name.

This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town hall and drop into any mailbox.

You can use this form to:

- register or pre-register to vote in Massachusetts; and/or
- update your name, address, and political party.

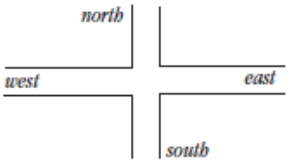
To register or pre-register to vote in Massachusetts you must:

- **BE A U.S. CITIZEN;** and
- be a Massachusetts resident; and
- be at least 16 years old.

Penalty for Illegal Registration: Fine of not more than $10,000 or imprisonment for not more than five years or both.
-Massachusetts General Laws, chapter 56 section 8.

Identification To Be Provided

Section 7 requires you to include your driver's license number or the last 4 digits of your social security number on this application. This information will be verified through the Registry of Motor Vehicles and the Commissioner of Social Security. If the information cannot be verified or you do not provide this information, you must provide identification either with this application or at your polling location when you go to vote. Sufficient identification includes a copy of a current and valid photo identification, current utility bill, bank statement, government check, paycheck or other government document showing your name and address.



†Using landmarks, draw the location of the place where you live if you cannot describe that location as a number and street or as a rural route and box number.

Print all information in black ink. Follow above instructions for proper delivery.

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1	**Check one:** Are you a Citizen of the United States of America? ☐ Yes ☐ No NOTE: If you checked "no," do not complete this form.
2	**Full name:** *last name* *first name* *middle name or initial* *Jr. Sr. II III IV (circle one if appropriate)*
3	**Former name:** *last name* *first name* *middle name or initial* *Jr. Sr. II III IV (circle one if appropriate)*
4	**Address where you live now** (*street number / street name / rural route number & box number / apartment number / city or town / zip code*):
5	**Address where you receive all your mail** (if different from #4):
6	**Date of birth:** *month day year*
7	**Identification #:** *license # or last 4 digits of SSN*
8	**Telephone** (optional): ___ *Check if unlisted*
9	**Party enrollment or designation** (check one): ☐ *Democratic* ☐ *Republican* ☐ *Green-Rainbow* ☐ *Libertarian* ☐ *No Party (unenrolled)* ☐ *Political Designation (not a political party)*:
10	**Address at which you were last registered to vote** (*street number / street name / rural route number & box number / apartment number / city or town / zip code*):
11	If the applicant is unable to sign this form, give the name, address and telephone number (optional) of the person helping the applicant: *name* *address* *telephone number (optional)*
12	**I hereby swear (affirm)** that I am the person named above, that the above information is true, that **I AM A CITIZEN OF THE UNITED STATES,** that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.
13	**Today's date:** *month day year*
14	**Signed:** *Sign your name here.*
	Agency Designation: G

Rev. 12/13/18

Check to make sure that you have completed all the information on the voter registration affidavit on the opposite side!

This form must be received by the local Board of Registrars or Election Commission or postmarked on or before the deadline for voter registration (listed below) for that election, primary, preliminary or town meeting.

DEADLINES FOR VOTER REGISTRATION

To participate in...	You must register...
state primaries *state elections* *city and town preliminaries* *city and town elections* *regularly scheduled town meetings*	*at least 20 days before*
special town meetings	*at least 10 days before*

If you do not hear from your local election officials in 2 or 3 weeks, please call them!

Fold along dotted line.

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Board of Registrars or Election Commission

City or Town Hall

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YOUR CITY OR TOWN *ZIP CODE FOR CITY OR TOWN HALL*

Return Address

name

number and street

MA

city or town *zip code*

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