

# Affidavit for Proof of Massachusetts Residency for Health Coverage

2/14/2018

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