**Affidavit for Proof of Residency**

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,

2/14/2018

, live at .

I certify that I, beginning on

, have lived at this residence for

. 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