More Than Just Insurance.
Plymouth Rock assurance®

Health Insurance Affidavit

To complete this form **by hand**:

1 Print all pages of the form.
2 Complete the form by filling in each space with black or blue ink. Do not use pencil.
3 When finished, have your signature notarized before mailing the form to Plymouth Rock's Claims Department at the address provided at the end of the form.

Or

To complete this form **electronically**:

1 Save this writable PDF to your computer, then open it using Adobe's Acrobat Reader.
2 Complete the form by typing in each field and/or checking the appropriate buttons. *Tip: you can tab from field to field.*
3 When finished, save and print the form and have your signature notarized before mailing the form to Plymouth Rock's Claims Department at the address provided at the end of the form.

Complete this form to the best of your knowledge and belief. DO NOT GUESS at any answers. If you don't know the answer to a question, leave that field blank. Please call your Claim Representative if you need help.

CLAIM NUMBER	*(12-digit number)*

In accordance with Chapter 273 of the Acts of 1988, insurance companies are required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before they can process your claim for Personal Injury Protection Benefits.

IF YOU DO NOT have health insurance of your own, or benefits available through a household member, please skip to Section Three (next page). PLEASE NOTE that if you do not have health insurance of your own, or benefits available through a household member, your signature must be notarized.

SECTION ONE: Benefits Information

To be completed if you have **health benefits available to you.**

First Name of Insured:	**Last** Name of Insured:
Health Insurance Company:	Policy Number:
Policyholder's First & Last Name: *(If different than name of insured)*	
Deductible Amount: $	and/or Co-Insurance: *(Amount paid by you)* $

Policyholder Signature

/ /

Date

SECTION TWO: Additional Benefits Information

To be completed in addition to Section One, if you are **entitled to other health benefits through any other policy** (i.e., spouse, parent, legal guardian).

Health Insurance Company:	Policy Number:
Policyholder's First & Last Name:	Relationship: *(i.e., Spouse, Parent, Legal Guardian)*
Deductible Amount: $	and/or Co-Insurance: *(Amount paid by you)* $

Policyholder Signature

/ /

Date

Form continues

Health Insurance Affidavit (continued)

SECTION THREE

I certify that I do not have any accident and/or health benefits available to me through either my own policy or that of a household member.

X ______________________________ ___ / ___ / ___

Policyholder Signature ***(To be signed in the presence of a Notary Public.)*** Date

YOUR SIGNATURE MUST BE NOTARIZED.
Please bring this form to a Notary Public. Sign on the line above in their presence and have your signature notarized.

State of: ____________ County of: ____________

On this ______ day of ______________________, 201__, before me, the undersigned notary public, personally appeared ______________________________, proved to me through satisfactory evidence of identity, being in this instance ______________________________, and acknowledged to me that he/she signed the foregoing voluntarily and for its stated purpose.

Notary Public Signature: X ______________________ My Commission Expires: ___ / ___ / ___

Return This Form To

Claims Department
Plymouth Rock Assurance Corporation, PO Box 9112, Boston, MA 02112-9112

Thank you.

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