QUALIFIED ASSOCIATION MEMBERSHIP VERIFICATION FORM

Company Name: _____

Doing Business As *(if applicable)*:_____

Address: _____

City/Town:_____ **State**:_____ **ZIP Code**:_____

Contact: _____

Phone: _____ **Email**:_____

Affiliated Qualified Association:

☐ Retailers Association of Massachusetts ☐ Massachusetts Package Store Association

It is understood that membership in one of the aforementioned associations is required to obtain health insurance coverage from the Retailers Association of Massachusetts Health Insurance Cooperative. I hereby certify that the business listed above is a current member of the association indicated on this form.

Signed:_____

Date: _____

Name *(please print):* _____