NAGE/SEIU Local 5000

TRIAL COURT OF MASSACHUSETTS

Health and Welfare Fund

Statement of Verification
Student Coverage

Name of Insured: _____ SS#: _____

Address: _____

_____

_____

Place of Employment: _____

Name of Student: _____

Date of Birth: _____ Age: _____

Name of College or University: _____

Expected Date of Graduation: _____

The above student is currently enrolled as a full time student in our educational institution for the Spring _____ / Fall _____ Semester of _____.

Name of College or University: _____

Name of Registrar: _____ Date: _____

Signature of Registrar or Designee: _____

AFFIX SCHOOL STAMP OR SEAL BELOW

Please return completed form to:

Fund Office
159 Burgin Parkway, First Floor
Quincy, MA 02169-4213

159 Burgin Parkway | Quincy, MA 02169
phone: 617-479-5814 | toll free: 1-800-641-0700 | fax: 617-773-8637