

TRIAL COURT OF MASSACHUSETTS

Health and Welfare Fund

Enrollment Form

Employee Information

Social Security Number: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work Phone Number: _____

Title: _____ Work Location: _____

Date of Birth: _____ Sex: Male Female

Marital Status: Single Married Divorced

Dependent Information

Relationship Codes: 2-Spouse* 3-Child*** 4-Stepchild** 5-Disabled Child** 6-Legal Custody**
(*Marriage Certificate Required) (**Verification Required) (***)Birth Certificate)

Table with 6 columns: First Name, Last Name, SS#, Date of Birth, Sex, Relationship Code. It contains four rows of input fields for dependent information.

Signature of Employee: _____