

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: _____

<p>The above student is currently enrolled as a full time student in our educational institution for the Spring _____ / Fall _____ Semester of _____.</p> <p>Name of College or University: _____</p> <p>Name of Registrar: _____ Date: _____</p> <p>Signature of Registrar or Designee: _____</p> <p><u>AFFIX SCHOOL STAMP OR SEAL BELOW</u></p>
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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