

Commonwealth of Massachusetts/NAGE

Health and Welfare Trust Fund

Enrollment Form

Use this form to list your eligible dependents.

Employee Information

Social Security Number: _____ Date of Birth _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work Phone Number: _____

Email Address: _____ Bargaining Unit: _____

Date of Hire: _____

Dependent Information (verification required)

Spouse - Marriage Certificate Required

Child - Birth Certificate Required

Disabled Child - Verification Required

Legal Custody - Verification Required

Over Age Dependent (19-23) - Student Verification Required each semester

First Name	Last Name	Relationship	Date of Birth	Sex
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

If applicable - You must submit a copy of your marriage certificate and/or birth certificates when adding eligible dependents

Signature of Employee: _____ Date: _____