

**APPLICATION FORM for RETIREES DEATH BENEFITS  
MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND**

I, \_\_\_\_\_ do hereby make application for a paid-up death benefit certificate in accordance with the rules, regulations and eligibility requirements of the Fund. Date of Birth: \_\_\_\_\_ Date Retired: \_\_\_\_\_

I certify that during the last Five (5) years, I have been employed by:

COMPANY NAME	FROM	TO
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby designate as my beneficiary to receive the proceeds of the Death Benefit:

\_\_\_\_\_ of \_\_\_\_\_  
(NAME) (ADDRESS)

whose relationship to me is that of \_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SOCIAL SECURITY NO.

\_\_\_\_\_  
LOCAL UNION #