**MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND**
**14 New England Executive Park, Suite 200**
**Burlington, MA 01803-5201**

# DEPENDENT ENROLLMENT FORM

**Fax: 781-238-0703**

Member Name: ______________________ ______________ __________ ______________
Last Name | First Name | Middle Initial | Local Union #

Social Security Number (SS#): ______________________

Address: ______________________ ______________ __________ ______________
Street | Apt. No. | City | State | Zip Code

Spouse's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Dependent Child's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Dependent Child's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Dependent Child's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Dependent Child's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Dependent Child's Name: ______________________ ______________ ______________________
Date of Birth | Social Security Number (SS#)

Please Print Information

I hereby certify that the above information is correct, and that each person listed has been issued that Social Security Number by the federal government of the United States. I further understand that any incorrect or misleading information could result in termination of benefits for me and my dependent(s).

______________________________ ______________
Member's Signature | Date