Benefit Services
SERVING LOCAL UNION 725 & MCASF
15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

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MCASF Local 725 HEALTH & WELFARE TRUST FUND
ANNUAL FAMILY STATEMENT

Dear Participant,

In order to ensure that the Plan has up-to-date information on you and your family members, the Plan requires that you complete and return this form each year regardless of whether or not you have made any changes. If you do not provide this information by **NOVEMBER 1, 2025**, the Plan **will suspend** your benefits until the information is received. Please sign and return this form to Benefit Services in the enclosed envelope or fax to (754) 999-2205. You may also submit this statement to your participant portal under forms.

Please Clearly Print Your Information

First	Middle	Last
Address		Social Security #
City, State, ZIP		Medicare Claim #
Date of Birth	Phone	Cell Phone
Email Address		
Current Work Status [ ] Active [ ] Retired [ ] Disabled [ ] COBRA		Employer
Marital Status [ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widow		Date of Marriage/Divorce
Marital Status Change in the last year? [ ] YES [ ] NO		You must inform Benefit Services within 30 days of your marriage or divorce.

Spousal and Dependent Coverage Request

*(Please complete the following two (2) sections to **PROVIDE COVERAGE** to your spouse and dependents under age 26, if you are adding a dependent for the first time, you will be required to submit additional documents such as birth certificate. If you are **not** providing coverage to your spouse or dependent, you may **skip** these two (2) next sections.)*

Spouse Information

First	Middle	Last
Date of Birth	Social Security #	Medicare Claim #
Address		Phone
City, State, ZIP		Email Address

Dependents Information

Name	Relation to Mbr	Gender	Date of Birth	Social Security #	Medicare Claim #

(Use additional paper for more dependents)

Other Insurance Inquiry for Coordination of Coverage

(Please complete this portion of the form if you, your spouse or any of your dependents have other insurance coverage that you participate in, or if there has been any change in the other insurance Coverage)

Name of Insured Person		
Relation to Member		Date of Birth
Insurance Company		Phone
Policy #	Effective Date	Termination Date
Type of Coverage [ ] Medical [ ] Prescription [ ] Dental		Provided by Employer
List Who Is Covered By Other Insurance		

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify Benefit Services immediately should any of my dependents listed on my coverage become eligible for any other coverage. Any material submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

Member's Signature _____ Date _____

STOP! Sign & Date Before Sending

In this section, please print your information.

If you are on Medicare, please add your Medicare Benefit ID # in this box.

Enter your work status and employer here.

Enter your marital status here. Please note that you must inform Benefit Services within 30 days of a change to your marital status.

If you are electing to provide coverage to your spouse and/or dependent child(ren) under age 26 enter their information in this section.

If your spouse is on Medicare, please add her Medicare benefit ID # in this box.

BE ADVISED! You will be responsible for any claims paid for your ex-spouse if you do not inform Benefit Services within 30 days of your divorce.

Add your under age 26 dependent child (ren) information in this section. If your dependent is on Medicare, please add their Medicare Benefit ID# in these boxes. Please note you must inform Benefit Services immediately when your dependent is no longer eligible.

VERY IMPORTANT SECTION! If your spouse and/or dependent child has coverage through another source, please add that information to this section. Coordination of Coverage is important for you; dual coverage can save you money on your claim's copayments.

You must sign this form as you are certifying that the information is accurate and truthful. Any false or misleading information will be referred to Fund Legal Counsel for appropriate action.

Add date you signed the form