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

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. We may need to send you important information regarding the plan, or to ensure that your benefits are being paid, so please complete all sections of this statement including your phone and email address. If you do not provide this information by **NOVEMBER 30, 2020**, the Plan will suspend your benefits until the information is received. Please sign and return this form to the Benefit Office in the enclosed envelope or fax to (754) 999-2205.

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		

Spouse Information

First	Middle	Last
Date of Birth		Social Security #
Email Address		Medicare Claim #

Dependents Information

Name	Relation to Mbr	Gender	Date of Birth	Social Security #	Medicare Claim #
		M / F			
		M / F			
		M / F			
		M / F			
		M / F			
Use additional paper for more dependents					

Other Insurance Inquiry

(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 the Benefit Office immediately should any of my dependents listed on my coverage becomes eligible for any other coverage. Any material submitted by myself or on behalf of any eligible person that contain 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 _____ Sign Here

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MCASF Local 725 HEALTH & WELFARE TRUST FUND
BENEFICIARY ELECTION FORM

Member's Name_____ SSN_____

Address _____

Below, please indicate the person(s) you wish to be named as beneficiary(ies) of any death benefits through the MCASF Local 725 Health & Welfare Trust Fund.

NOTE: If you are legally married at the time of your death, Federal law and the Benefit Fund requires that benefits be paid to your surviving spouse, unless your spouse consents to the payment of the benefit to someone else. To make that type of change, the Benefit Fund will require a notarized statement from your spouse – see bottom of this form for notarized consent by your spouse.

BENEFICIARY DESIGNATION_____

Primary Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

Primary Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

In the event your Primary Beneficiary(ies) pre-deceases you, the below list of Contingent Beneficiary(ies) will be paid based on the percentage you indicate.

Contingent Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

Contingent Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address_____

(Attach additional paper if necessary, please ensure to indicate "primary" or contingent" and percentage)

I understand that this beneficiary designation cancels any previous designation I may have made and will be effective when received in the Fund Office and only if received prior to my death. Further, I understand that this designation shall be cancelled if my current marriage ends and I remarry, which would make my legal spouse at the time of my death my new beneficiary.

Member's Signature _____ Date _____ SIGN HERE

SPOUSAL CONSENT OF ALTERNATE BENEFICIARY DESIGNATION AS NOTE ABOVE_____

I hereby consent to my spouse's designation of the above beneficiary for death benefits payable through the Benefit Fund. I fully understand that by signing below, I will not be eligible for the receipt of the benefits payable on behalf of my spouse in the event of his or her death.

Spouse's Signature _____
Date _____

Subscribe to and sworn to before me,
this _____ day of _____, 20_____
Notary Public Signature _____
County of _____ State of _____
My Commission expires _____