November 1, 2021

ANNUAL FAMILY STATEMENT

Dear Participant,

To ensure that the MCASF Local 725 Health & Welfare Fund has up-to-date information on you and your family members, the Board of Trustees requires that all eligible participants complete and return the Annual Family Statement each year.

By completing this statement, the Fund (which is Self-Funded) is able to continue to provide the best available health coverage to those who are eligible under the rules of the Plan. This also allows the Fund to accurately communicate important information regarding your benefits.

All eligible participants in the Health Fund are required to submit the Annual Family Statement, **failure to remit the statement <u>will</u> result in a suspension of your coverage and delay in payment of any benefit claims**.

If you need to change your beneficiary, you may download a beneficiary election form from our website at https://www.725benefits.org or you can change your beneficiary election directly in your participant portal on our website.

Please remit your Annual Family Statement by **December 15th** to prevent any suspension of your coverage.

Sincerely,

Eligibility Department
MCASF Local 725 Health & Welfare Fund

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 **DECEMBER 15, 2021**, 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