Benefit Services
SERVING LOCAL UNION 725 & MCASF
15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
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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. 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 _____