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

November 1, 2023

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.

Why is this information required? The MCASF Local 725 Health & Welfare Fund is self-funded, which simply means we pay for each approved claim submitted by participants. Trustees of the plan have a fiduciary duty to ensure that plan assets are used appropriately, meaning solely for the benefit of eligible participants – Local 725 members and their eligible dependent family members. The Annual Family Statement allows the plan to ensure plan dollars are being used appropriately, to minimize waste & fraud. This helps plan dollar go further to provide benefits for Local 725 members. It also allows the plan to communicate important information to you 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**.

Whether you have or have not had any changes since you completed the last Annual Family Statement or enrollment form, you **<u>must</u>** still submit this statement before the due date noted below. If you are adding a new dependent, you will be required to provide additional documentation for that dependent such as birth certificate and so forth.

You may complete an electronic copy of the Family Statement securely on our website at **https://www.725benefits.org** in your participant portal (click on  icon at top of website) document is in the Form section on lefthand side once you log in. Our website also has FAQs about your healthcare as well as other helpful information and links. Visit it today!

Please remit your Annual Family Statement by **December 1st** to prevent any suspension of your coverage and delay in payment of your health and prescription claims.

Sincerely,

Eligibility Department
MCASF Local 725 Health & Welfare Fund

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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 **DECEMBER 1, 2023**, 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. 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		

Spouse Information

*(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) sections.)*

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 #
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 the Benefit Office 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 _____ Sign Here