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
ENROLLMENT & VITAL INFORMATION FORM

Please Clearly Print or Type Your Information		
First	Middle	Last
Address		Social Security #
City, State, ZIP		UA #
Date of Birth	Phone	Cell Phone
Email Address		Date of Hire
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