

Check List of Items/Documentation to Submit with Your MCASF Local 725 Health Fund's Enrollment & Vital Form

Please utilize the check list below to ensure that you have all necessary documents to complete your enrollment form for health coverage. This will expedite the enrollment process. Missing documents and incomplete forms will delay the processing of your enrollment.

FORMS / INQUIRIES

- Member Enrollment Form
- Other Insurance Inquiry
- HIPAA Release Form
- Beneficiary Election Form

DOCUMENTATION / PROOF FOR YOU

- Copy of your birth certificate
- Copy of your state photo ID
- Copy of your Social Security Card

DOCUMENTATION / PROOF FOR YOUR SPOUSE (if applicable)

- Copy of spouse birth certificate
- Copy of spouse state photo ID
- Copy of spouse Social Security Card
- Copy of your marriage certificate

DOCUMENTATION / PROOF FOR YOUR DEPENDENTS (if applicable)

- Copy of dependent's birth certificate
- Copy of dependent's state photo ID
- Copy of dependent's Social Security Card
- Copy of tax return claiming dependent stepchild(ren)

OTHER REQUIRED DOCUMENTATION

- Copy of any previous divorce decrees, Qualified Domestic Relations Order, Separation Agreement

Please! Review the Enrollment Form you are submitting to make sure that you have completed all blanks, signed where necessary and answered any questions accurately and completely.

How to Complete Your MCASF Local 725 Health Fund's Enrollment & Vital Information Form



15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

PLEASE PRINT CLEARLY & LEGIBLY

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.

In this section, please print your information.

Enter your work status and employer here.

Enter your marital status here. Please note that you must inform Benefit Services within 30 days of a change to your marital status.

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 <u>not</u> 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)					

If you are electing to provide coverage to your spouse and/or dependent child(ren) under age 26 enter their information in this section.

If your spouse is on Medicare, please add her Medicare benefit ID # in this box.

BE ADVISED! You will be responsible for any claims paid for your ex-spouse if you do not inform Benefit Services within 30 days of your divorce.

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			

Add your under age 26 dependent child (ren) information in this section. If your dependent is on Medicare, please add their Medicare Benefit ID# in these boxes. Please note you must inform Benefit Services immediately when your dependent is no longer eligible.

The above information is true and accurate to the best of my knowledge and belief. I am also 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

You must sign this form as you are certifying that the information is accurate and truthful. Any false or misleading information will be referred to Fund Legal Counsel for appropriate action.

Add date you signed the form

VERY IMPORTANT SECTION! If your spouse and/or dependent child has coverage through another source, please add that information to this section. Coordination of Coverage is important for you; dual coverage can save you money on your claim's copayments.

**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*					
<i>*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 <u>not</u> providing coverage to your spouse or dependent, you may skip these two (2) next sections.</i>					
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**			
<i>**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</i>			
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 _____





15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

**MCASF LOCAL 725 EMPLOYEE BENEFIT TRUST FUNDS
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 for the following Fund(s).

MCASF LOCAL 725 PENSION FUND

MCASF LOCAL 725 HEALTH & WELFARE FUND

MCASF LOCAL 725 DEFINED CONTRIBUTION RETIREMENT 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



SPOUSAL CONSENT OF ALTERNATE BENEFICIARY DESIGNATION _____

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 Signed in Front of Notary

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



15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Member/Retiree Section

I _____ authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information including mental health about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA Contact Person
MCASF Local Union 725 Health & Welfare Trust Fund
c/o Benefit Services
15800 Pines Blvd., Suite 201
Pembroke Pines, FL 33027

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

Signature of Member: _____ **Date Signed:** _____

-OR- I do not want my Health Information including mental health released to anyone but myself.

Signature of Member: _____ **Date Signed:** _____

Spouse Section

I, the spouse (Name, please print) _____, Social Security Number _____ have also read, understand and authorize the Plan to disclose claims, payment, eligibility, and other related health information including any mental health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse: _____ **Date Signed:** _____

-OR- I do not want my Health Information including mental health released to anyone but myself.

Signature of Spouse: _____ **Date Signed:** _____



Dependent(s) Over the Age of 18 Section

I, the dependent child(ren) over age 18 (Name, please print) _____,
Social Security Number: _____ have also read, understand, and authorize the Plan to disclose
claims, payment, eligibility, and other related health information including mental health about me to the following
persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such
persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent: _____ **Date Signed:** _____

-OR- [] I do not want my Health Information including mental health released to anyone but myself.

Signature of Dependent: _____ **Date Signed:** _____

I, the dependent child(ren) over age 18 (Name, please print) _____,
Social Security Number: _____ have also read, understand, and authorize the Plan to disclose
claims, payment, eligibility, and other related health information including mental health about me to the following
persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such
persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent: _____ **Date Signed:** _____

-OR- [] I do not want my Health Information including mental health released to anyone but myself.

Signature of Dependent: _____ **Date Signed:** _____

NOTE: If there is more dependent(s) over the age of 18, please copy, complete and sign the appropriate number
of additional Authorization Forms and return to the Benefit Office.