



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 ANNUAL FAMILY STATEMENT

Member Information (Please Complete ALL Information - Print Clearly)					
First		Middle		Last	
Address				Social Security #	
City, State, ZIP				Medicare Claim #	
Date of Birth		Gender		Phone #	
Email Address				Cell Phone #	
Your Current Work Status	☐ Active	☐ Retired	☐ Disabled	☐ COBRA	(Check One Box)
Your Employer					
Your Current Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widow (Check One Box)
Date of Marriage/Divorce			Did Your 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, social security card and photo ID. 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	Gender	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 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