Benefit Services
SERVING LOCAL UNION 725 & MCASF

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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 **NOVEMBER 1, 2024**, 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 _____

STOP!
Sign & Date
Before Sending