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

Dear Participant,

The MCASF Local 725 Health & Welfare Fund is committed to maintaining accurate and up-to-date information for all eligible participants and their dependent family members. To help us accomplish this, the Board of Trustees requires all eligible participants to complete and submit an **Annual Family Statement each year**.

Why Is This Information Required?

The MCASF Local 725 Health & Welfare Fund is a self-funded health plan, which means the Fund pays approved claims using plan assets. The Board of Trustees has a fiduciary responsibility to ensure that these assets are used appropriately and solely for the benefit of eligible Local 725 members and their eligible dependents.

The Annual Family Statement helps the Fund:

- Verify that participant and dependent information is current and accurate.
- Ensure benefits are being provided only to eligible individuals.
- Minimize waste, fraud, and improper use of plan resources.
- Help protect plan assets so they can continue providing valuable benefits to Local 725 members and their families.
- Maintain accurate contact information so important benefit-related communications can reach you.

Annual Submission Is Required

All eligible Health Fund participants must complete and submit the Annual Family Statement each year, even if there have been no changes to your information.

Failure to submit the statement by the deadline may result in **suspension of your health coverage and delays in the payment of health and prescription benefit claims.**

If you are adding a new dependent, you may be required to provide supporting documentation, such as a birth certificate, social security card, photo ID and other applicable documentation.

How to Submit Your Statement

You can submit your Annual Family Statement in the enclosed return envelope, you can fax to us at (754) 999-2205 or you can email it to us at info@725benefits.org,

Additionally, you can securely complete and submit the Annual Family Statement electronically through the participant portal on our website:

www.725benefits.org

After logging into your participant portal, select the **Forms** section on the left-hand side of the page to access the Annual Family Statement.

The website also provides frequently asked questions, healthcare information, and other helpful resources regarding your benefits.

Important Deadline: November 1, 2026

Please submit your **Annual Family Statement by November 1** to avoid suspension of your coverage and delays in the payment of health and prescription claims.

Thank you for your prompt attention and cooperation in helping us maintain accurate records and protect the benefits provided to you and your family as a member of UA Local 725.

Sincerely,
Eligibility Department
MCASF Local 725 Health & Welfare Fund

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MCASF LOCAL 725 HEALTH & WELFARE TRUST FUND
ANNUAL FAMILY STATEMENT

Please complete your statement fully as all information noted is required. Please print clearly & submit before deadline!

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 <<		

In this section, please print clearly your information.

If you are on Medicare, please add your Medicare Benefit ID # in this box.

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, 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.*

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

Spouse Information			
First	Middle	Last	
Date of Birth	Gender	Social Security #	Medicare Claim #
Address		Phone #	
City, State, ZIP		Email Address	

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

Dependents Information					
Name	Relation to Mbr	Gender	Date of Birth	Social Security #	Medicare Claim #
(Use additional paper for more dependents)					

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 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.

STOP! Sign & Date Before Sending

Member's Signature _____ Date _____

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.

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

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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.

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