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

October 1, 2025

### **ANNUAL FAMILY STATEMENT**

Dear Participant,

To ensure that the MCASF Local 725 Health & Welfare Fund has up-to-date information on you and your family members, the Board of Trustees requires that all eligible participants complete and return the Annual Family Statement each year.

# Why is this information required?

The MCASF Local 725 Health & Welfare Fund is self-funded, which simply means we pay for each approved claim submitted by participants. Trustees of the plan have a fiduciary duty to ensure that plan assets are used appropriately, meaning solely for the benefit of eligible participants — Local 725 members and their eligible dependent family members. The Annual Family Statement allows the plan to ensure plan dollars are being used appropriately, to minimize waste & fraud. This helps the plan dollar go further to provide benefits for Local 725 members. It also allows the plan to communicate important information to you regarding your benefits.

All eligible participants in the Health Fund are required to submit the Annual Family Statement, failure to remit the statement <u>will</u> result in a suspension of your coverage and delay in payment of any benefit claims.

Regardless of if you have or have not had any changes since you completed the last Annual Family Statement or Enrollment Form, you <u>must</u> still submit this statement before the due date noted below. If you're adding a new dependent, you will be required to provide additional documentation for that dependent such as birth certificate and so forth.

You may complete an electronic copy of the Family Statement securely on our website at https://www.725benefits.org in your participant portal (click on icon at top of page) document is in the Form section on lefthand side once you log in. Our website also has FAQs about your healthcare as well as other helpful information and links. Visit it today!

Please submit your Annual Family Statement by **November 1**<sup>st</sup> to prevent any suspension of your coverage and delay in payment of your health and prescription claims.

Sincerely,

Eligibility Department
MCASF Local 725 Health & Welfare Fund





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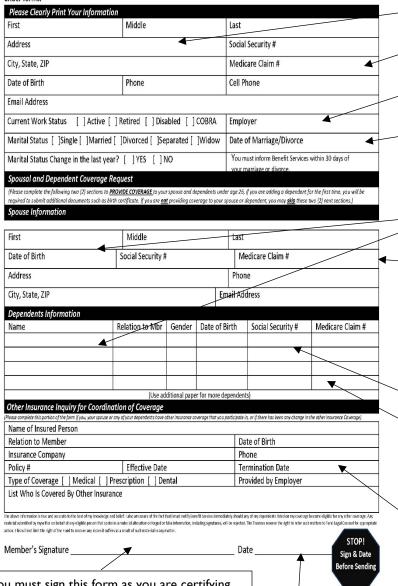


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### MCASF Local 725 HEALTH & WELFARE TRUST FUND ANNUAL FAMILY STATEMENT

#### 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, 2025, the Plan will suspend your benefits until the information is received. Please sign and return this form to Benefit Services in the enclosed envelope or fax to (754) 999-2205. You may also submit this statement to your participant portal under forms.



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

In this section, please print 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 <u>must</u> inform Benefit Services within 30 days of a change to your marital status.

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.

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 <u>immediately</u> when your dependent is no longer eligible.

**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.



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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, 2025, the Plan will suspend your benefits until the information is received. Please sign and return this form to Benefit Services 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		
	Wildule						
Address				S	Social Security #		
City, State, ZIP				٨	Medicare Claim #		
Date of Birth	Phone				Cell Phone		
Email Address	1						
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		
Spousal and Dependent Coverage Request					vour marriage or divorce.		
(Please complete the following two (2) sections to <u>PRO</u> required to submit additional documents such as birth <b>Spouse Information</b>	<b>VIDE COVERAGE</b> to you						
First	Middle				Last		
Date of Birth	Social Security #				Medicare Claim #		
Address					Phone		
City, State, ZIP					nail Address		
Dependents Information							
Name	Relation to Mbr	Gender	Date	of Birt	:h	Social Security #	Medicare Claim #
Other Insurance Inquiry for Coordinat	•	ditional pape	r for mo	re depe	ndent	ts)	
(Please complete this portion of the form if you, your spouse or an		other insurance co	verage that	t you part	icipate i	n, or if there has been any change in t	the other insurance Coverage)
Name of Insured Person							
Relation to Member					Date of Birth		
surance Company					Phone		
Policy #	Effective Date				Termination Date		
Type of Coverage [ ] Medical [ ] Prescription [ ] Dental					Provided by Employer		
List Who Is Covered By Other Insurance	e						
The above information is true and accurate to the best of my knowledge and b material submitted by myself or on behalf of any eligible person that contains action. This will not limit the right of the Fund to recover any losses it suffers a	a material alteration or forged or	false information, inc					

Member's Signature \_\_\_\_\_ Date Sign & Date **Before Sending**