For MPE Use Only:_____

Massachusetts Public Employees Fund

Vision and Dental Health Care Plans

Member Information

Dental ID# or Social Security Number: _____

Name: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____ May we leave a voicemail? ☐Yes ☐No

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

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Dependent Information

Relationship Codes: 2=Spouse 3=Child 4=Stepchild 5=Disabled Child 6=Legal Custody 7=Ex-spouse

***You must provide a valid copy of your marriage certificate if adding a spouse. You must provide a valid copy of a birth certificate if adding your natural child or step-child. Additionally, you must complete a Step-Child Verification form or a Determination of Disability, as appropriate. You must provide legal documents and a Legal Custody attestation form for a child for whom you have legal custody. These additional forms can be obtained from our website, www.mpefund.org, or you may contact the Fund office.**

*Documentation Required for Adding Dependents

FAILURE TO SUBMIT THIS FORM WITH ALL REQUIRED DOCUMENTATION WILL RESULT IN YOUR REQUEST BEING DENIED. YOU MUST ALLOW 7 – 10 BUSINESS DAYS FROM OUR RECEIPT OF REQUIRED INFORMATION FOR DEPENDENTS TO BE UPDATED IN OUR CLAIMS PROCESSING SYSTEM. PLEASE TAKE THIS INTO CONSIDERATION WHEN MAKING DENTAL AND/OR VISION APPOINTMENTS.

First Name	Last Name	Date of Birth (Mo/Day/Year)	Gender	Relationship Code
_____	_____	___/___/____	☐M ☐F	____
_____	_____	___/___/____	☐M ☐F	____
_____	_____	___/___/____	☐M ☐F	____
_____	_____	___/___/____	☐M ☐F	____
_____	_____	___/___/____	☐M ☐F	____

Signature of Fund Member (required): _____Date: _____

Under penalties of perjury, I certify that the above dependent(s) meet the definition of an eligible dependent as defined by the Fund. I understand the Fund reserves the right to request additional documentation to support this information. I also understand that if any of the above-named dependent(s) are found to not qualify as an eligible dependent that I may be required by the Fund to repay any and all overpayments paid by the Fund on their behalf.

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