For MPE use only____________

Massachusetts Public Employees Fund
Vision and Dental Health 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	MI	Last Name	Date of Birth Mo/Day/Year	Gender	Relationship Code
____________		____________	___/___/____	☐M ☐ F	________
____________		____________	___/___/____	☐M ☐ F	________
____________		____________	___/___/____	☐M ☐ F	________
____________		____________	___/___/____	☐M ☐ F	________
____________		____________	___/___/____	☐M ☐ F	________

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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 payments paid by the Fund on their behalf.

Due to privacy laws, the Fund cannot accept emails containing sensitive enrollment information. You must either mail or fax all documents to the address/fax number below.

PO Box 3319, Peabody, MA 01961-3319 (800) 325-5214 (617) 426-4440 Fax (617) 426-4411 mpefund.org
v. 2022.11