For MPE use only_____

Massachusetts Public Employees Fund
Vision and Dental Health Plans

Coverage for Ex-Spouse

The Massachusetts Public Employees Fund will continue to provide vision and dental health benefits for your former spouse ***unless***:

***Case 1*:** Your divorce is final and you have remarried; or

Case 2: Your divorce is final and your ex-spouse has remarried; or

***Case 3*:** Your divorce is final and the Divorce Decree states that you are no longer required to provide medical and/or dental and vision insurance for your former spouse (or your former spouse is responsible for maintaining their own insurance); or

Case 4: Your former spouse is eligible for his/her own dental and/or vision benefit (i.e., through their own employer).

Below is a checklist for documentation that must be submitted in each Case above:

Case 1: You have remarried.

- ☐ You must submit a copy of your new marriage certificate, **and**
- ☐ You must submit a copy of your Certificate of Divorce Absolute; **and**
- ☐ You must also submit your ex-spouse's last known address below.

Case 2: Your ex-spouse has remarried.

- ☐ You must submit a copy of your Certificate of Divorce Absolute, **and**
- ☐ You must provide the Fund with an approximate date of remarriage (if known) here _____ (insert date), **and**
- ☐ You must submit your ex-spouse's last known address below.

Case 3: You are not responsible for maintaining medical, health and/or dental and vision insurance for your former spouse according to your Divorce Agreement.

- ☐ You must submit a copy of your Certificate of Divorce Absolute; **and**
- ☐ You must submit your ex-spouse's last known address below.

Case 4: Your ex-spouse is eligible for their own vision and/or dental plan.

- ☐ You must submit a copy of your Certificate of Divorce Absolute; **and**
- ☐ You must sign below that, to the best of your knowledge, your ex-spouse maintains their own vision and or/dental plan; **and**
- ☐ You must submit your ex-spouse's last known address below.

Member Name: _____

Former spouse's name: _____

Last known address (This is necessary for the Fund to comply with COBRA Continuation of Coverage Policies:

_____

Member Signature: _____ Date: _____

By signing above, and including the documentation as required in the appropriate Case, I am attesting that I have read and understand the Fund's policy regarding continuation coverage on behalf of my ex-spouse and that I am requesting that my former spouse be removed from my vision and dental health plan accordingly.

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