Member Change Form

DCUE Dental Reimbursement Fund

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952-432-4033 dental@dcue.org

Member Name: _____ Today's Date: _____
Employee Number: _____ Effective Date of Status Change: _____

Type of Change
Please check all that apply

□ Address
□ Email Address
□ Spouse/Dependent Add/Remove
□ Name Change
□ Phone Number
□ Marital Status

Address: _____
_____

City: _____ State: _____ Zip Code: _____

Phone: _____

Email Address: _____

Name Change:
This should be the name as it appears on your Social Security card. Checks will be issued to the name provided.

Original Name: _____

New Legal Name: _____

Dependent Add/Remove: *Circle one.*
Your dependent children can be covered under you until age 26.

Dependent Name: _____
First Middle Initial Last

Dependent DOB: _____ Dependent Gender: Male Female

Dependent Name: _____
First Middle Initial Last

Dependent DOB: _____ Dependent Gender: Male Female

Marital Status Change: *Circle one.* Married Divorced Legally Separated Effective Date: _____

Spouse Add/Remove: *Circle one.*
Your spouse (dependent) can be covered under you.

Spouse Name: _____
First Middle Initial Last

Spouse DOB: _____ Spouse Gender: Male Female

Employee Signature: _____ Date:_____

Please contact us with any questions