Member Change Form

DCUE Dental Reimbursement Fund

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
- □ Dependent Add/Remove
- □ Name Change
- □ Phone Number
- □ Marital Status

Address: ____
____

City: ____________________________ State: ________ Zip Code: _____________

Phone: ______________________________

Email Address: ____

<u>Name Change:</u>
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: ____

<u>Dependent Add/Remove:</u>
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

<u>Marital Status Change:</u> Married Divorced Legally Separated

Dependent Name: ____
First Middle Initial Last

Dependent DOB: ____________________ Dependent Gender: Male Female

Employee Signature: ____ Date:_______________

Please feel free to contact us with any questions