Dependent or beneficiary revision form

Purpose
Update dependent beneficiary information.

Eligible dependents
The following dependents are eligible for medical, dental, vision or life coverage:

- Child placed in the employee's home for adoption under age 26.
- Natural, adopted, foster or step child under age 26.
- Natural, adopted or step child disabled prior to age 26 as defined by 42, U.S.C. 1382C.
- Person under age 26 for whom the employee has court-ordered guardianship.
- Spouse.

Submit form and required documents via email or fax.

Email: humanresources-benefits@exchange.asu.edu

Fax: 480-993-0007

Questions?
855-278-5081
HRESC@asu.edu

Provide copies of the following documentation for covered dependents. Federal law requires social security numbers for all dependents covered under employer-sponsored healthcare plans.

Dependent	Revision needed	Required documentation
Spouse	Name	Driver's license
	Date of birth	Driver's License or birth certificate
	SSN	U.S. Social Security card **Legal name required.**
Child	Name	Birth certificate
	Date of birth	Birth certificate
	SSN	U.S. Social Security card **Legal name required.**

Documentation requirements for beneficiaries is not required.

More information

- Eligibility and Enrollment section of the Benefits Guide | Administration
- Designating your life insurance beneficiaries.
- When submitting by email:
    - You must use your ASU email account (asu.edu).
    - You must type [SECURE] in the subject line, including the square brackets.
    - Do not forward or copy others on the email.
    - This box does not send replies or responses to inquiries.

Dependent or beneficiary revision form

Employee information

Last name:	First name:	MI:
Employee ID:	ASU ID:	

Dependent or beneficiary information

☐ Revise ☐ Remove

Full legal name: Last First Middle			
Date of birth:	Social security number:		
Relationship:	Gender:	☐ Male	☐ Female

☐ Revise ☐ Remove

Full legal name: Last First Middle			
Date of birth:	Social security number:		
Relationship:	Gender:	☐ Male	☐ Female

☐ Revise ☐ Remove

Full legal name: Last First Middle			
Date of birth:	Social security number:		
Relationship:	Gender:	☐ Male	☐ Female

☐ Revise ☐ Remove

Full legal name: Last First Middle			
Date of birth:	Social security number:		
Relationship:	Gender:	☐ Male	☐ Female

I hereby certify under penalty of perjury that the information I have provided is accurate. I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action and potential prosecution pursuant to ARS §13-2310, 12-2311, 12-2702 and other applicable provisions of the law. I understand that my request to remove a person means that they will remain in the system but their Dependent Beneficiary Type will be none—neither dependent nor beneficiary.

Signature:	Date: