



# DEPENDENT/BENEFICIARY PERSONAL DATA UPDATE FORM

Use this form change incorrect information about a dependent and/or beneficiary.

## INSTRUCTIONS

### PURPOSE

To allow employees to correct dependent and/or beneficiary information they have previously data entered or submitted incorrectly.

### ELIGIBLE DEPENDENTS

The following are considered eligible dependents for medical, dental, and vision coverage (please refer to the Benefits Guide at [http://www.asu.edu/hr/benefits/insurance\\_programs.html](http://www.asu.edu/hr/benefits/insurance_programs.html) for more details on dependent eligibility criteria):

- Legal Spouse
- Domestic Partner, subject to approval
- Child (natural born, adopted, stepchild, child of domestic partner, court-ordered guardianship, foster child, placed for adoption or disabled child)
- Older child, subject to approval

**SUBMIT THE ATTACHED FORM PLUS REQUIRED DOCUMENTS**

**FAX** 480.993.0007

### IN PERSON

ASU Human Resources  
1551 S Rural Rd. | Tempe  
(Rural & Spence)

### MAIL

ASU Human Resources  
PO Box 875612  
Tempe, AZ 85287-5612

**QUESTIONS?** 480.965.2701

## UPDATING DEPENDENT INFORMATION

Specific documentation **MUST** be submitted with the *Dependent/Beneficiary Personal Data Update Form* to meet Dependent eligibility criteria.

DEPENDENT	CORRECTION NEEDED	DOCUMENTATION REQUIRED
Spouse or Domestic Partner	Name	Copy of Drivers License
	Date of Birth	Copy of Drivers License or Birth Certificate
	SSN	Copy of Social Security Card <b>MUST HAVE CORRECT LEGAL NAME</b>
Child	Name	Copy of Birth Certificate
	Date of Birth	Copy of Birth Certificate
	SSN	Copy of Social Security Card Must have correct legal name
<b>NOTE: Medicare requires you to provide a Social Security number for all dependents covered under an employer medical, dental or vision plan.</b>		

## BENEFICIARY

A beneficiary is a person or a Trust designated as the recipient of funds from a life insurance policy upon the death of the insured. Multiple beneficiaries can be named, either on an individual policy, or across multiply policies. Beneficiaries **DO NOT** have to be family members.

## UPDATING BENEFICIARY INFORMATION

Complete the attached *Dependent/Beneficiary Personal Data Update Form*.  
No additional documentation is needed.

**FAX completed form and supporting documents: 480.993.0007**

**MAIL/BRING TO:** ASU Human Resources | 1551 S. Rural Rd. (PO Box 875612) | Tempe, AZ 85287-5612

**QUESTIONS?** 480.965.2701

ASU Office of Human Resources | Rev. 08.18.09



# DEPENDENT/BENEFICIARY PERSONAL DATA UPDATE FORM

Use this form change incorrect information about a dependent and/or beneficiary.

## EMPLOYEE INFORMATION:

Last Name: _____	First Name: _____	MI: _____
Empl ID: _____	ASU ID: _____	

## DEPENDENT / BENEFICIARY INFORMATION:

1. Full Legal Name: _____	<i>Last</i>	<i>First</i>	<i>Middle</i>
Date of Birth: _____ (mm/dd/yy)	Social Security #: _____		
Relationship: _____	<input type="checkbox"/> Dependent <input type="checkbox"/> Beneficiary		
2. Full Legal Name: _____			
Date of Birth: _____ (mm/dd/yy)	Social Security #: _____		
Relationship: _____	<input type="checkbox"/> Dependent <input type="checkbox"/> Beneficiary		
3. Full Legal Name: _____			
Date of Birth: _____ (mm/dd/yy)	Social Security #: _____		
Relationship: _____	<input type="checkbox"/> Dependent <input type="checkbox"/> Beneficiary		

## DOCUMENTATION

DEPENDENT	CORRECTION NEEDED	DOCUMENTATION REQUIRED
<b>Spouse or Domestic Partner</b>	Name	Copy of Drivers License
	Date of Birth	Copy of Drivers License or Birth Certificate
	SSN	Copy of Social Security Card <b>MUST HAVE CORRECT LEGAL NAME</b>
<b>Child</b>	Name	Copy of Birth Certificate
	Date of Birth	Copy of Birth Certificate
	SSN	Copy of Social Security Card Must have correct legal name

**NOTE: Medicare requires you to provide a Social Security number for all dependents covered under an employer medical, dental or vision plan.**

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits for dependent/beneficiary is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action and potential prosecution pursuant to ARS sections 13-2310, 12-2311, 12-2702 and other applicable provisions of the law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FAX completed form and supporting documents: 480.993.0007**

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