

MEMBERS ONLY

CHANGE OF ADDRESS / INFORMATION FORM

Please Print Clearly

Entered

Official Use Only

Member / Participant _____

Health ID Number ELH999 _____

Social Security No. _____

Date of Birth _____

Membership Status (Active) (Retired) (Withdrawl) _____

Please list, by name, those family members to which this address change applies:

Spouse: _____

Dependents: _____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Old Information

Street or P.O. Box _____

City, State, Zip _____

New Information

Street or P.O. Box _____

City, State, Zip _____

Home Phone: _____ Cell Phone: _____

Email: _____

Note/Comments _____

Signature _____

Date _____