CHANGE OF ADDRESS

(TO BE COMPLETED BY THE PARTICIPANT)

*****PLEASE PRINT ALL INFORMATION*****

PARTICIPANT NAME:_____

PARTICIPANT SOCIAL SECURITY NUMBER OR MEMBER IDENTIFICATION NUMBER:_____

LOCAL UNION #:_____PARTICIPANT DATE OF BIRTH:_____

PLEASE CHANGE MY ADDRESS **FROM**:

_____

_____

_____

PHONE NUMBER:_____

TO:

_____

_____

_____

PHONE NUMBER:_____

EFFECTIVE DATE OF ADDRESS CHANGE:_____

PARTICIPANT SIGNATURE:_____

(NOTE: *This change cannot be made without participant signature*)

RETURN THIS COMPLETED FORM TO:

EDWARD W. SPARROW HOSPITAL ASSOCIATION MNA EMPLOYEES HRA
6525 Centurion Drive
Lansing, MI 48917 – 9275

THIS SECTION – FUND OFFICE USE ONLY

Date changed on BMS:_____ By:_____

Date changed on BCBSM:_____ By:_____

Date changed on Pension:_____ By:_____