

**SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND
DRUG & GENERAL SALES EMPLOYERS TRUST FUNDS**



Phone: 323-666-8910 Fax: 323-913-0484

Return form to:
So. Calif. Drug Benefit Fund
P.O. Box 27920
Los Angeles, CA 90027

CHANGE OF ADDRESS FORM

The Trust Fund recently sent you a notice that was returned by the U.S. Postal Service indicating a Forwarding Address.

Type of Document Returned: Claims Correspondence/Check/EOB Open Enrollment Material
 Pension Plan Summary Annual Report Other: _____
(This mail will be held until this signed Change of Address Form is received in our office.)

You have otherwise indicated that you wish to change your address with the Trust Fund.

For your protection, all address changes must be submitted to the Trust Fund Office in writing, signed by the Participant. Please fill out the form below and return to the above address or to your Union Local Insurance Office. The Trust Fund cannot change your address without your signature.

PARTICIPANT INFORMATION:

(Please print clearly with blue or black ink)

| | | | |
|--|-------------------------------------|--|--------------------------------------|
| Last _____ First _____ MI _____ | | Who is Requesting Address Change? | |
| ID#: DF: _____ | or XXX-XX- _____ | 1. <input type="checkbox"/> Participant Only 2. <input type="checkbox"/> Participant's Entire Family 3. <input type="checkbox"/> Dependent Only: (see below) | |
| Fund ID # or last 4 digits of Participant's SSN _____ | Date of Birth _____ | | |
| Participant's Union Local _____ | Participant's Employer _____ | If Box 3 is checked, above please indicate below Full Name of Dependent requesting correspondence and claim information to be sent to separate address from Participant. | |
| If this Address Change is for a Dependant only , please indicate Dependant Name: | Dependent First and Last Name _____ | Date of Birth _____ | Dependent Signature / Guardian _____ |

OLD ADDRESS:

| | | | |
|--------------|------------|-------------|-----------|
| Street _____ | City _____ | State _____ | Zip _____ |
|--------------|------------|-------------|-----------|

NEW ADDRESS:

| | | | | |
|--------------------|--------------------------------|------------|-------------|-----------|
| Street _____ | Apt. _____ | City _____ | State _____ | Zip _____ |
| Phone Number _____ | Effective Date of Change _____ | | | |

I hereby request that my address be changed: _____

Signature

Date

For Office Use Only

| UNION LOCAL | Date | Initials | TRUST FUND: | Date | Initials |
|---|-------------|----------|--|------|----------|
| <input type="checkbox"/> Copy to Trust: | | | <input type="checkbox"/> System Updated: | | |
| | | | <input type="checkbox"/> Return Mail handled | | |
| Notes _____ | Notes _____ | | | | |