



P.O. Box 40187, Portland, Oregon 97240-0187  
 (503) 224-7377 or 1-800-768-7377

**ADDRESS CHANGE FORM**

Member's Name: \_\_\_\_\_

Member's Social Security Number: \_\_\_\_\_

**CURRENT HEALTH PLAN**

Clear Choice       Kaiser Permanente       ODS       Providence

**OLD ADDRESS:**

\_\_\_\_\_  
 (Residence address)

\_\_\_\_\_  
 (Mailing address if different)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (County)

\_\_\_\_\_  
 (Phone number)

**NEW ADDRESS:**

\_\_\_\_\_  
 (Residence address)

\_\_\_\_\_  
 (Mailing address if different)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (County)

\_\_\_\_\_  
 (Phone number)

**Are you moving outside of the service area of your current health plan?**       Yes     No

**IF YES, YOU MUST TERMINATE YOUR CURRENT HEALTH PLAN, AND ENROLL IN A HEALTH PLAN THAT OFFERS COVERAGE IN YOUR NEW AREA. PLEASE SELECT YOUR NEW HEALTH PLAN ON THE ENCLOSED INTENT/ENROLLMENT FORM.**

Members Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Power of Attorney Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please enclose a copy of the Power of Attorney if the Power of Attorney is signing for the member.