



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

PacificSource 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.