

Change of Address Form

The contact information you provide will be used to update the records maintained at both the Motion Picture Industry Pension Plan and the Motion Picture Industry Health Plan. Please submit a completed form to the California Plan Office each time this information changes. To validate this information, **your signature is required**. To ensure you receive important Plan information, always report changes in your contact information immediately.

Name: _____ Participant ID or SSN: _____ Birth Date: _____

Check one: Participant Pensioner/Survivor Spouse Child

New Street Address Unit # City State ZIP

Home Phone Daytime Phone FAX E-Mail Address

Signature Date

Reminder: All Employers, Locals, Credit Unions, etc. that you belong to must be notified separately of your change in contact information.

**If your dependent or beneficiary address is different, please complete the section below
with the dependent's full name and complete address.**

(Please include the individual's Social Security Number if one is available.)

Name: _____ SSN _____ E-mail _____

Address _____ City _____ State _____ ZIP _____

Check one: Same as above New address

Phone _____ Relationship _____ Birth Date _____

Name: _____ SSN _____ E-mail _____

Address _____ City _____ State _____ ZIP _____

Check one: Same as above New address

Phone _____ Relationship _____ Birth Date _____

Name: _____ SSN _____ E-mail _____

Address _____ City _____ State _____ ZIP _____

Check one: Same as above New address

Phone _____ Relationship _____ Birth Date _____

Name: _____ SSN _____ E-mail _____

Address _____ City _____ State _____ ZIP _____

Check one: Same as above New address

Phone _____ Relationship _____ Birth Date _____