

## Change of Address Form

Participant Name:  Effective Date of Change:

ID #:  Group Number:

**Check the box that the address change applies to:**

Participant Only     Entire Family

**If this address change applies only to spouse or dependent(s), check the appropriate box and list name(s) below:**

Spouse/ Over Age 18 Dependent Only\*     Dependent under age 18\* not living with employee

Spouse's Name:

Dependent's Name:

Dependent's Name:

Due to HIPAA regulations, we must receive a signature for each dependent over age 18, including your spouse, in order to change their address. If this change will also apply to any dependent over 18, please print this form and have each dependent over 18 sign it.

**OLD ADDRESS:**

Street:

City:

State:  Zip Code:

**NEW ADDRESS:**

Street:

City:

State:  Zip Code:

Participant's Signature:

Date:

**Signature of Spouse/Dependent Over Age 18 is required if address is different than the Participant.**

Spouse Signature:  Date:

Dependent (Over 18) Signature:  Date:

Dependent (Over 18) Signature:  Date:

All Explanation of Benefits and Payments will be sent to the address on record for each individual over 18 years old.

Once completed and signed, return this form to Allegiance via fax or US Mail at:

**FAX: 800-257-0950**

**ATTENTION: Enrollment Department**

**MAIL: Allegiance**

**ATTENTION: Enrollment Department**

**P.O. Box 3018**

**Missoula, MT 59806**

**Please also notify your Employer's benefits department.**