

**CHANGE OF ADDRESS**  
(TO BE COMPLETED BY THE PARTICIPANT)

FUND NAME: Michigan BAC Health Care Fund

**\*\*\*PLEASE PRINT ALL INFORMATION\*\*\***

PARTICIPANT NAME: \_\_\_\_\_

PARTICIPANT SOCIAL SECURITY NUMBER: \_\_\_\_\_

LOCAL UNION #: \_\_\_\_\_ PARTICIPANT DATE OF BIRTH: \_\_\_\_\_

PLEASE CHANGE MY ADDRESS FROM:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**TO:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

EFFECTIVE DATE OF ADDRESS CHANGE: \_\_\_\_\_

PARTICIPANT SIGNATURE: \_\_\_\_\_

*(NOTE: This change cannot be made without participant signature)*

**RETURN THIS COMPLETED FORM TO:**

FUND OFFICE  
6525 Centurion Drive  
Lansing, MI 48917 – 9275

**THIS SECTION – FUND OFFICE USE ONLY**

Date changed on BMS: \_\_\_\_\_ By: \_\_\_\_\_

Date changed on BCBSM: \_\_\_\_\_ By: \_\_\_\_\_

Date changed on Pension: \_\_\_\_\_ By: \_\_\_\_\_