



Western States Insulators and Allied Workers' Pension Plan  
Western States Insulators and Allied Workers' Individual Account Plan  
Western States Insulators and Allied Workers' Health Plan

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## ADDRESS CHANGE FORM

In order to have verification of your requested address change for our files, please complete the information below and send this form back to the Trust Fund Office. The address change will not take place until the form has been returned to our office and we have the proper authorization, in writing, along with your signature.

I \_\_\_\_\_, authorize the Trust Fund Office to make the following change  
(Please Print Name)

effective as of \_\_\_\_\_.  
(Date of Change)

MY NEW ADDRESS IS:

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

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

**PLEASE RETURN WITH A COPY OF YOUR PHOTO ID**