E Benefits Administration

Employee Change of Address

Employer Name _____ Effective Date _____

Employee Name _____ Social Security Number _____

OLD ADDRESS:

Home Address _____ Home Phone Number _____

City/State _____ Work Phone Number _____

Zip _____

NEW ADDRESS:

Home Address _____ Home Phone Number _____

City/State _____ Work Phone Number _____

Zip _____

Signature _____

Today's Date _____

Fill out completely and submit to:

E Benefits Administration

Fax 888-876-1058

Email: claims@ebenefitsadministration.com

Mail: PO Box 190466, Boise, ID 83719-0466