MILA

Managed Health Care Trust Fund

111 BROADWAY, Suite. 502 - NEW YORK, NY 10006

Tel: ☎ 212-766-5700 ♦ Fax: 212-766-0844/0845

E-mail: info@milamhctf.com

CHANGE OF ADDRESS FORM – (PLEASE PRINT)

Member's Name_____
Last Name **First Name** **Middle**

Member SS#:_____-_____-_____

Member Phone# :_(_____) _____-_____

E-Mail Address: (*If applicable*)_____

Telephone #: Home:_____**Cell#:**_____

Old Home Address: Street: _____**Apt**_____

_____

City:_____**State**_____**Zip:**_____

New Home Address: Street:_____**Apt**_____

_____

City:_____**State**_____**Zip:**_____

Member's Signature: _____**Date:**_____

==========

FOR MILA USE ONLY:

Date Received _____ **By:** _____

Date Entered _____

☐**Faxed** ☐**E-Mailed** ☐**US Post** ☐**Other**_____