



## **CHANGE OF ADDRESS REQUEST**

TFO Completed: \_\_\_\_\_/By\_\_\_\_\_

*For members of:*

**District Council 16 Health and Welfare Trust Fund**

**Northern California Glaziers, Architectural Metal and Glass Workers Trust Funds**

**Bay Area Painters and Tapers Trust Funds**

**Resilient Floor Pension Trust Fund**

*Please update my address for the following plan(s):*

- |  |                     |   |
|--|---------------------|---|
| <input type="checkbox"/> District Council 16 Health and Welfare Plan | Phone: 800-922-9902 | Email: <a href="mailto:dc16info@hsba.com">dc16info@hsba.com</a>           |
| <input type="checkbox"/> Northern California Glaziers Pension        | Phone: 800-222-6298 | Email: <a href="mailto:glaziersinfo@hsba.com">glaziersinfo@hsba.com</a>   |
| <input type="checkbox"/> Bay Area Painters and Tapers Pension        | Phone: 866-894-3705 | Email: <a href="mailto:paintersinfo@hsba.com">paintersinfo@hsba.com</a>   |
| <input type="checkbox"/> Resilient Floor Pension Trust Fund          | Phone: 800-782-0010 | Email: <a href="mailto:resilientinfo@hsba.com">resilientinfo@hsba.com</a> |
| <input type="checkbox"/> Glaziers IARP – John Hancock                | Phone: 800-222-6298 | Email: <a href="mailto:glaziersinfo@hsba.com">glaziersinfo@hsba.com</a>   |
| <input type="checkbox"/> Painters Annuity – John Hancock             | Phone: 866-894-3705 | Email: <a href="mailto:paintersinfo@hsba.com">paintersinfo@hsba.com</a>   |

In order to update your mailing address for your Pension and your Health and Welfare plans, you must submit your change of address by signature and in writing. Please complete the necessary information as indicated below.

**Participant Name:** \_\_\_\_\_

**Last four digits of SSN:** \_\_\_\_\_

**WE DO NOT ENCOURAGE ELECTRONIC TRANSMITTAL OF DOCUMENTS CONTAINING YOUR FULL SOCIAL SECURITY NUMBER**

**Local Union#:** \_\_\_\_\_

**OLD ADDRESS:**

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

**NEW ADDRESS:**

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

**New Address Effective Date:**

\_\_\_\_\_

**Email Address:**

\_\_\_\_\_

**Telephone Number:**

(\_\_\_\_\_) \_\_\_\_\_

**Mobile Number:**

(\_\_\_\_\_) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MAIL, FAX (925) 833-7301, or EMAIL this form to:**

Health Services & Benefit Administrators  
4160 Dublin Boulevard, Suite 100  
Dublin, CA 94568