REQUEST FOR CHANGE OF ADDRESS

PLEASE PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURE.

NAME OF DIET DRUG RECIPIENT (DDR):____

DDR'S SOCIAL SECURITY NUMBER: ____

DDR'S CLAIM NUMBER: 18300-____

OLD ADDRESS:____

____

____

NEW ADDRESS:____

____

____

OLD AREA CODE & PHONE NUMBER: DAY ____

EVENING ____

NEW AREA CODE & PHONE NUMBER: DAY ____

EVENING ____

***SIGNATURE:** ______________________________________**DATE**____________________

SIGNATURE OF DDR OR LEGAL REPRESENTATIVE IS REQUIRED FOR REQUEST TO BE CONSIDERED VALID.

Mail to: **AHP SETTLEMENT TRUST**
1100 E. Hector Street Suite 450
Conshohocken, PA 19428

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