DESERT HOSPITAL RETIREMENT PROTECTION PLAN

CHANGE OF ADDRESS FORM

Participant Information:

Name:____ Social Security #:________-______-________

Old Address:____

City:______________________________________ State:_________ Zip Code: _________________

New Address: ____

City:______________________________________ State:_________ Zip Code: _________________

Telephone Number: (   )_____________________________

New Address Effective Date: __________________________

____ ______________________

Participant's Signature Date