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

PLEASE PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURE.