

# 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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