

**CO-OP RETIREMENT PLAN CHANGE OF ADDRESS FORM**

Participant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

FORMER ADDRESS

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

NEW ADDRESS

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

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

Printed Name: \_\_\_\_\_

Please Mail or fax this form to:

UNITED BENEFITS GROUP  
PO BOX 169005  
KANSAS CITY, MO 64116

Fax: 816-459-8750