



North Atlantic States Carpenters  
Health Benefits Fund

Massachusetts Office  
350 Fordham Road  
Wilmington, MA 01887  
www.carpentersfund.org  
Phone: 800-344-1515  
Fax: 978-752-1164

Connecticut Office  
10 Broadway  
Hamden, CT 06518  
www.ctcarpentersfunds.org  
Phone: 800-922-6026  
Fax: 203-230-5958

**Alternate Address Request for Health Benefits Fund Correspondence**

Upon receipt of completed form, the address will be updated for Dependents listed in Section 2 of this form.

I \_\_\_\_\_, (Please Print Full Name) pursuant to the HIPAA regulation dated August 14, 2002, am requesting that the North Atlantic States Carpenters Health Benefits Fund mail all my correspondence to the address indicated in **Section 2** of this form.

**Section 1: Employee Information (Subscriber of Coverage)**

Employee Name: \_\_\_\_\_  
Employee Address: \_\_\_\_\_  
Employee ID#(SS#): \_\_\_\_\_ - \_\_\_\_\_  
Employee Phone #: ( ) \_\_\_\_\_

**Section 2: Alternate Address Information for Covered Spouse/Dependent**

*Part 1*

Dependent Name: \_\_\_\_\_  
Dependent Address: \_\_\_\_\_  
(Address you wish Health Fund to mail all your correspondence)  
Dependent SS#: \_\_\_\_\_ - \_\_\_\_\_  
Dependent Phone #: ( ) \_\_\_\_\_

*Part 2*

**Additional Covered Dependents**

*The Health Fund will also change the correspondence address for all Dependents identified below.*

Dependent Name: _____	Dependent SS#: _____ - _____
Dependent Name: _____	Dependent SS#: _____ - _____
Dependent Name: _____	Dependent SS#: _____ - _____
Dependent Name: _____	Dependent SS#: _____ - _____

\_\_\_\_\_  
(Please PRINT Name of Person making this request)

\_\_\_\_\_  
(SIGNATURE of Person Making this request)

\_\_\_\_\_  
(DATE of Signature)

**Please mail completed form to the attention of the Privacy Officer, at the address listed above.**