

**MUNICIPAL HEALTH BENEFIT PROGRAM  
P.O. BOX 188  
NORTH LITTLE ROCK, AR 72115  
(501) 978-6137  
FAX (501) 537-7265**

**CHANGE OF ADDRESS**

Name of Group/Employer:		Group Number	
Name of Member / Employee			SSN
<b>Old Mailing Address</b>			
City	State	Zip	Phone Number ( )

<b>New Mailing Address</b>			
City	State	Zip	Phone Number ( )

\_\_\_\_\_  
Member/Employee Signature

\_\_\_\_\_  
Date

**Please send this form to MHBP at the above address or fax number.**