



# LABORERS' HEALTH & WELFARE TRUST FUND OF WESTERN CANADA

## CHANGE OF ADDRESS REQUISITION

MEMBER INFORMATION			
LAST NAME		FIRST NAME	
LOCAL UNION	CERTIFICATE NUMBER	DATE OF BIRTH (MM/DD/YY)	GENDER Male Female
PHONE NUMBER		EMAIL ADDRESS	

NEW ADDRESS			
ADDRESS			PHONE NUMBER
CITY	PROVINCE	POSTAL CODE	E-MAIL ADDRESS

OLD ADDRESS			
ADDRESS			PHONE NUMBER
CITY	PROVINCE	POSTAL CODE	E-MAIL ADDRESS

SIGNATURE	
Please note we cannot change your address without your true signature. Electronic signatures are not accepted.	
Please sign in pen. Electronic signatures are not accepted. (MM/DD/YY)	
SIGNATURE OF MEMBER	DATE