

ADDRESS CHANGE FORM

POLICYHOLDER INFORMATION

Policyholder (Full Corporate/Legal Name)	
Current Address (Number/Street/City/State/Zip)	
Contact Person (Title)	Telephone ()
New Address (Number/Street/City/State/Zip)	
Contact Person (Title)	Telephone ()

BILLING ADDRESS (If Different than Policyholder Address)

Current Address (Number/Street/City/State/Zip)	
New Address (Number/Street/City/State/Zip)	

DIVISION ADDRESS (Division Location that is Changing)

Division Name
Current Address (Number/Street/City/State/Zip)
New Address (Number/Street/City/State/Zip)

Name/Title of Policyholder Representative
Signature
On _____ (Mo/Day/Yr) At _____ (City/State)

Return completed form to:
Administrative Services
300 Southborough Dr. Ste. 200 South Portland, ME 04106-6914
Phone: 800-877-2701; Fax: 877-820-5311