CHANGE OF ADDRESS AUTHORIZATION FORM

Explanation

This address authorization form is to inform the Retirement Plan for CTA Employees and the Health Care Trust that I have a new mailing address. Please update your records to replace my previous address.

PARTICIPANT'S CURRENT ADDRESS

First Name | Middle Name | Last Name

Street Address | Apartment Number

City | State | Zip Code

Home Phone Number | Mobile Phone Number | Email

Badge Number | Social Security Number

PARTICIPANT'S NEW PHYSICAL ADDRESS

Street Address | Apartment Number

City | State | Zip Code

Home Phone Number | Mobile Phone Number | Email

PARTICIPANT'S NEW MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS

Street Address | Apartment Number

City | State | Zip Code

Home Phone Number | Mobile Phone Number | Email

SIGNATURE

All participants must sign and return this form with a clear copy of a valid state issued driver's license or ID.

Participant's Signature | Date