



**SAN DIEGO PHYSICIANS MEDICAL GROUP/  
SCRIPPS PHYSICIANS MEDICAL GROUP ("SDPMG/SPMG")  
MEMBER MAILING ADDRESS CHANGE REQUEST**

Name	
DOB	
Health Plan ID #	
New Street Address	
New City	
New Zip	

Please list the name and date of birth for any MINOR dependents that this change will apply for. A separate address request form is required for each ADULT on this policy.

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To protect your privacy, please include a copy of your health plan ID card AND documentation of your new address (for example a utility bill with your name and address or an ID card with name and new address, etc.).

I hereby authorize SDPMG/SPMG to update the mailing address as indicated above. I understand that this will only update the records for SDPMG/SPMG and that it is my responsibility to provide updates to my health care provider(s) and my health plan.

X \_\_\_\_\_  
(PLEASE PRINT or TYPE YOUR NAME)

X \_\_\_\_\_ DATE: \_\_\_\_\_  
(PLEASE SIGN)

*This form should be mailed or faxed to the address below –*

***ATTN. Eligibility Department  
6760 Top Gun Street, Suite 100 . San Diego, CA 92121-4152  
Telephone (858) 824-7000; Fax (858) 824-7047***