



**THE KLAMATH TRIBES MEMBERS BENEFITS DEPARTMENT**

501 CHILOQUIN BLVD., PO BOX 436

CHILOQUIN, OREGON 97624

**MEMBER BENEFITS ADDRESS UPDATE FORM**

*Each member age 18 and older must fill out and sign his/her own form; addresses will not be changed without your signature. Please do not forget to update minor children. Please Print legibly or type.*

**Name:** \_\_\_\_\_ **Maiden Name:** \_\_\_\_\_  
Legal name

**Date of Birth:** \_\_\_\_\_ **Roll #:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**OLD ADDRESS**

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ - \_\_\_\_\_ **County:** \_\_\_\_\_

**NEW ADDRESS**

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ - \_\_\_\_\_ **County:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Type of #:** H  Wk  Cell  Msg  E-mail: \_\_\_\_\_

PLEASE LIST ALL MINORS WHO ARE AFFECTED BY THIS CHANGE OF ADDRESS!	
Name:	Date of Birth:

I certify that I am the above named person and that all of the information is true and accurate, and I am an enrolled member of The Klamath Tribes. I understand there may be times when I may request tribal, state, and federal assistance that will require an income verification of my annual per capita revenues; I release the Klamath Tribes to provide this information as requested. Yes:  No:  Initial: \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
*If member is a minor child, signature of parent, legal guardian is required.*

**FOR INTERNAL USE ONLY:**

Enrollment Verified: Enrolled:  Not Enrolled  Year of Eligibility: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Initial and date MB DB/File: \_\_\_\_\_