WORKERS' COMPENSATION COMMISSION

EMPLOYER OR SELF-INSURED EMPLOYER REQUEST FOR CHANGE OF ADDRESS

This form is to be used only to change the address of an employer or self-insured employer. Using the form will change the mailing address in all claims that are registered with the Commission at the prior address shown below. You must include both the prior as well as the new address in order to make an address change. Incomplete requests will not be processed. This form may not be used to change an address in an individual claim.

Company Name _____

Federal Employer Identification Number (FEIN) _____

NEW ADDRESS

Street _____

Additional Info (Apt., Suite, etc.) _____

City _____ State _____ ZIP Code _____

PRIOR ADDRESS

Street _____

Additional Info (Apt., Suite, etc.) _____

City _____ State _____ ZIP Code _____

REQUESTED BY:

○ **Employer** ○ **Self-Insured Employer** ○ **Employer/Self-Insured Employer Attorney**

Name of Authorized Individual _____

Title _____ Telephone Number _____

_____ _____

Signature of Authorized Individual (REQUIRED) Date

Street Address _____

City _____ State _____ ZIP Code _____

Clear This Form

10 Ea 641
410-864-5100 ● Email: info@wcc.state.md.us ●Web: http://www.wcc.state.md.us