WORKERS' COMPENSATION COMMISSION

INSURER REQUEST FOR CHANGE OF ADDRESS

This form is to be used only to change the address of an insurer. 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.

Insurance Company Name _____

Federal Employer Identification Number (FEIN) _____

Insurance Company Subsidiaries/FEIN (Please attach additional pages as needed to list more than 10).

Subsidiary Name	**FEIN**

NEW ADDRESS:

Street _____

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

City _____ State _____ ZIP Code _____

PRIOR ADDRESS:

Street _____

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

City _____ State _____ ZIP Code _____

Requested by: ◯ **INSURER** ◯ **INSURER ATTORNEY**

Name of Authorized Individual _____

Title _____ Telephone Number _____

_____ Date _____

Signature of Authorized Individual (REQUIRED)

Street Address _____

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

City _____ State _____ ZIP Code _____

10 East Baltimore Street ● Baltimore, Maryland 21202-1641

410-864-5100 ● Ema **w.wcc.state.md.us**

Reset This Form