GEORGIA STATE BOARD OF WORKERS' COMPENSATION

STANDARD COVERAGE FORM

GROUP SELF-INSURANCE FUND MEMBERS PLEASE TYPE
DETAILED INSTRUCTIONS GIVEN ON BACK OF FORM

A. INFORMATION ABOUT THE FUND MEMBER

FILE SEPARATELY FOR EACH UPDATE

1. Insured Member	5. dba (Doing Business As, if applicable)
2. Member Address	6. New dba or New Location Address
3. Type of Business	7. Franchise/Store # (if applicable)
4. EFFECTIVE DATE (Original Effective Date of Fund Member)	8. Policy Number

B. CHANGES TO ORIGINAL POLICY / ACTION REQUIRED

❑ 1. ADD	New dba Name	Effective Date
❑ 2. ADD	New Location Address	Effective Date
❑ 3. CANCEL	Member Name Listed in Section A	Effective Date
❑ 4. CANCEL	dba Name Listed in Section A	Effective Date
❑ 5. CANCEL	Location Listed in Section A	Effective Date
❑ 6. REINSTATE	Name(s) in Section A	Effective Date

NAME CHANGE (New Name Should Appear in Section A)

❑ 7.	Member Name	Effective Date
❑ 8.	Old dba Name	Effective Date

ADDRESS CHANGE (New Address Should Appear in Section A)

❑ 9.	Member Address
❑ 10.	Old dba Address or Location Address

C. INFORMATION ABOUT THE GROUP FUND AND SERVICING AGENT

1.	Group Self-insurance Fund Name	SBWC ID# (five digit no.)
2.	Name and Address of Servicing Agent	
3.	Name (of Person Completing Form)	Phone and Ext.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Use form WC-11 to:

To notify Board of coverage of new fund member, complete Sections A and C.
To notify Board of changes/activity, (as listed in Section B) complete A, B, and C.

Mail to: Coverage Section
State Board of Workers' Compensation
270 Peachtree Street, NW
Atlanta, GA 30303-1299
404-656-3692

INSTRUCTIONS FOR COMPLETING FORM WC-11

SECTION A:

1. ENTER COMPLETE MEMBER NAME (IF NAME HAS CHANGED, PUT NEW NAME HERE).
2. ENTER ADDRESS OF MEMBER OFFICE (IF ADDRESS HAS CHANGED, PUT NEW ADDRESS HERE).
3. ENTER TYPE OF BUSINESS (I.E. general contractor, retail sales, restaurant, landscaping, etc.).
4. ENTER ORIGINAL EFFECTIVE DATE OF INSURED MEMBER.
5. ENTER DOING BUSINESS AS (dba) NAME WHEN DIFFERENT FROM MEMBER NAME. COMPLETE SEPARATE FORM WC-11 FOR EACH DIFFERENT (dba) NAME.
6. ENTER ADDRESS OF (dba) LOCATION (IF MORE THAN ONE LOCATION, USE SEPARATE FORM WC-11).
7. ENTER HERE IF A FRANCHISE OR "CHAIN" USES A STORE NUMBER TO IDENTIFY A SPECIFIC LOCATION.
8. ENTER POLICY NUMBER ISSUED WHEN INSURANCE IS PURCHASED.

SECTION B: CHECK EXACT ACTION(s) BEING TAKEN AND GIVE EFFECTIVE DATE OF ACTION.

1. ADD DOING BUSINESS AS (dba) NAME AS SHOWN IN SECTION A - (5).
2. ADD LOCATION ADDRESS AS SHOWN IN SECTION A - (6).
3. CANCEL MEMBER NAME AS IN SECTION A - (1).
4. CANCEL DOING BUSINESS AS (dba) NAME AS SHOWN IN SECTION A - (5).
5. CANCEL LOCATION ADDRESS AS SHOWN IN SECTION A - (6).
6. EFFECTIVE DATE OF REINSTATEMENT.
7. MEMBER NAME PRIOR TO NAME CHANGE.
8. DOING BUSINESS AS (dba) NAME PRIOR TO NAME CHANGE.
9. OLD MEMBER ADDRESS PRIOR TO ADDRESS CHANGE.
10. OLD DOING BUSINESS AS (dba) ADDRESS PRIOR TO ADDRESS CHANGE.

SECTION C:

1. COMPLETE GROUP SELF-INSURANCE FUND NAME - DO NOT USE ABBREVIATIONS OR INITIALS.
2. NAME AND ADDRESS OF THIRD PARTY ADMINISTRATOR PROCESSING CLAIMS.
3. NAME AND PHONE NUMBER (WITH EXTENSION) OF PERSON COMPLETING FORM - DO NOT USE INITIALS.