

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## STANDARD COVERAGE FORM

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

<b>A. INFORMATION ABOUT THE FUND MEMBER</b>	
<b>FILE SEPARATELY FOR EACH CORPORATE NAME</b>	
1. Insured Member (Corporate Name)	5. dba (Doing Business As, if applicable)
2. Corporate Address	6. dba Address (Location)
3. Type of Business	7. Franchise/Store # (if applicable)
4. EFFECTIVE DATE (Original Effective Date of Fund Member)	8. Policy Number

<b>B. CHANGES TO ORIGINAL POLICY / ACTION REQUIRED</b>		
<input type="checkbox"/> 1. ADD	dba Name	Effective Date
<input type="checkbox"/> 2. ADD	Location	Effective Date
<input type="checkbox"/> 3. CANCEL	Corporate Name	Effective Date
<input type="checkbox"/> 4. CANCEL	dba Name	Effective Date
<input type="checkbox"/> 5. CANCEL	Location	Effective Date
<input type="checkbox"/> 6. REINSTATE	Name(s) in Section A	Effective Date
<b>NAME CHANGE (New Name Should Appear in Section A)</b>		
<input type="checkbox"/> 7.	Old Corporate Name	Effective Date
<input type="checkbox"/> 8.	Old dba Name	Effective Date
<b>ADDRESS CHANGE (New Address Should Appear in Section A)</b>		
<input type="checkbox"/> 9.	Old Corporate Address	
<input type="checkbox"/> 10.	Old dba Name	

<b>C. INFORMATION ABOUT THE GROUP FUND AND SERVICING AGENT</b>		
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.sbcw.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 CORPORATE NAME (IF NAME HAS CHANGED, PUT NEW NAME HERE).
2. ENTER ADDRESS OF CORPORATE 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 CORPORATE 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 CORPORATE 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. CORPORATE NAME PRIOR TO NAME CHANGE.
8. DOING BUSINESS AS (dba) NAME PRIOR TO NAME CHANGE.
9. OLD CORPORATE 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.

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