GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF CHANGE OF TPA / SERVICING AGENT

The purpose of this form is to notify the Board of a change in the TPA/Servicing Agent. **This form must be completed by the Insurer, Self-Insurer or Group Fund no later than 30 days prior to the effective date of the change** and sent to the State Board of Workers' Compensation, 270 Peachtree Street NW, Atlanta, GA 30303-1299.

A TPA / Servicing Agent MUST be licensed by the Office of the Commissioner of Insurance pursuant to O.C.G.A. §33-23-100.

A. INSURER/SELF-INSURER/GROUP FUND

Name of Insurer / Self-Insurer / Group Fund	SBWC ID #	FEIN #	
Mailing Address	City	State	Zip Code
Corporate Contact Person	Title	Signature of Corporate Contact	
Date	Phone Number	E-mail address	

B. NAME OF CLAIMS OFFICE BEING TERMINATED

Name of Claims Office Being Terminated	Phone Number	FEIN #	
Mailing Address	City	State	Zip Code

C. NOTICE OF REPLACEMENT CLAIMS OFFICE

Name of New Claims Office			FEIN #
Mailing Address	City	State	Zip Code
Contact Name for Claims Handling	Title	Phone Number (toll-free if out-of-State of Georgia)	Fax Number
Primary E-mail Address for E-mail Notification	Secondary E-mail for E-mail Notification		**Effective Date of Replacement**

D. NOTICE OF ADDITIONAL CLAIMS OFFICE

The above-named Insurer / Self-Insurer / Group Fund has **OBTAINED** the services of the following claims office, as an additional claims office for the administration of workers' compensation claims.

Name of Additional Claims Office			FEIN #
Mailing Address	City	State	Zip Code
Contact Name for Claims Handling	Title	Phone Number (toll-free if out-of-State of Georgia)	Fax Number
Primary E-mail Address for E-mail Notification	Secondary E-mail for E-mail Notification		**Effective Date of Addition**

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).

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Complete section A, B and C to notify the Board when a claims office/claims office address is being terminated and replaced.
Complete section A and D to notify Board when an additional claims office/claims office address is being added.
Complete section A, B C and D to notify Board when a claims office is being terminated, replaced and an additional claims office is being added.

Section A

Insurer/Self-Insurer/Group Fund (all fields are mandatory in section A)

1. Name of insurer/self-insurer/group fund **(do not use acronyms)**
2. SBWC ID number (five digit number) – **(Not the five digit NACI number)** see our website www.sbwc.georgia.gov/sbwc-id to verify your number
3. FEIN number for the insurer/self-insurer/group fund
4. Mailing address, city, state, zip code
5. Corporate contact person
6. Title
7. Signature of corporate contact
8. Date the form is being completed
9. Phone number
10. E-mail address – this will be used by the Board for notifications/legal notices and may be given to the public

Section B

Name of Claims Office Being Terminated (mandatory when completing section C)

1. Name of claims office being terminated
2. FEIN # of the claims office being terminated
3. Mailing address, city, state, zip code of the claims office being terminated

Section C

Notice of Replacement of Claims Office (mandatory when completing section B)

1. Name of the new claims office replacing the claims office in Section B
2. FEIN number of the claims office
3. Mailing address, city, state and zip code of the office that will handling the claims - this is the address that will be used by the Board for notifications
4. Contact name for claims handling/title – this is the person the Board will contact if needed
5. Phone number – this should be a local or a toll free number **(remember this is the contact phone number given to the public)**
6. Fax number
7. Primary E-mail address – this will be used by the Board for notifications/legal notices and will be given to the public
8. Secondary e-mail – if applicable – will receive same notification/legal notices as primary
9. Effective date of the replacement

Section D

Notice of Additional Claims Office

1. Name of the claims office being added to list of authorized claims offices for the insurer/self-insurer/group fund
2. FEIN number
3. Mailing address, city, state and zip code – this is the address that will be used by the Board for notifications
4. Contact name for claims handling/title – this is the person the Board will contact if needed
5. Phone number – this should be a local or a toll free number **(remember this is the contact phone number given to the public)**
6. Fax number
7. E-mail address – this will be used by the Board for notifications/legal notices and given to the public
8. Secondary e-mail – if applicable – will receive same notifications/legal notices as primary
9. Effective date of the addition