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 Mailing Address	6. New DBA or New Location Mailing 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 Mailing 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

MAILING ADDRESS CHANGE (New Mailing Address Should Appear in Section A)

☐ 9.	Member Mailing Address
☐ 10.	Old DBA Address or Location Mailing Address

C. INFORMATION ABOUT THE GROUP FUND

1.	Group Self-insurance Fund Name		SBWC ID# (five digit no.)
2.	Mailing Address		
	City	State	Zipcode
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 MAILING 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 MAILING 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, Box 5.
2. ADD LOCATION MAILING ADDRESS AS SHOWN IN SECTION A, Box 6.
3. CANCEL MEMBER NAME AS IN SECTION A, Box 1.
4. CANCEL DOING BUSINESS AS (DBA) NAME AS SHOWN IN SECTION A, Box 5.
5. CANCEL LOCATION MAILING ADDRESS AS SHOWN IN SECTION A, Box 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 MAILING ADDRESS PRIOR TO MAILING ADDRESS CHANGE.
10. OLD DOING BUSINESS AS (DBA) MAILING ADDRESS PRIOR TO MAILING ADDRESS CHANGE.

SECTION C:

1. COMPLETE GROUP SELF-INSURANCE FUND NAME - **DO NOT USE ABBREVIATIONS OR INITIALS**.
2. MAILING ADDRESS, CITY, STATE, AND ZIP CODE.
3. NAME AND PHONE NUMBER (WITH EXTENSION) OF PERSON COMPLETING FORM - **DO NOT USE INITIALS**.