

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR CHANGE OF ADDRESS

Instructions: This form is to be used only to change certain addresses of record. For employees, this form only changes the employee's address in a specifically identified claim. For employers and attorneys, this form only needs to be filed once as this form will change information in every claim. Do not file this form if a party's address is correct, but improperly listed in a claim.

| A. EMPLOYEE CHANGE OF ADDRESS | | | | | | |
|-------------------------------|--------------------|---------------------|--------------------|-------|-------------------------|----------------|
| Board Claim Number | Employee Last Name | Employee First Name | | M.I. | SSN or Board Tracking # | Date of Injury |
| Old Phone Number | | | New Phone Number | | | |
| Old Address | | | New Address | | | |
| City | State | Zip Code | City | State | Zip Code | |
| Old E-mail Address | | | New E-mail Address | | | |

| B. ALL OTHER PARTY ADDRESS CHANGES | | | | | |
|--|-------|----------|--------------------|-------|----------|
| <input type="checkbox"/> EMPLOYER | | Name | | | FEIN |
| Old Phone Number | | | New Phone Number | | |
| Old Address | | | New Address | | |
| City | State | Zip Code | City | State | Zip Code |
| Old E-mail Address | | | New E-mail Address | | |

| | | | | | | |
|--|-------|---------------------------------------|--------------------------------|-------|----------|---------------|
| <input type="checkbox"/> ATTORNEY | | <input type="checkbox"/> For Employee | <input type="checkbox"/> Other | Name | | GA Bar number |
| | | <input type="checkbox"/> For Employer | | | | |
| Old Phone Number | | | New Phone Number | | | |
| Old Address | | | New Address | | | |
| City | State | Zip Code | City | State | Zip Code | |
| Old E-mail Address | | | New E-mail Address | | | |

| | | | | | |
|---|-------|----------|--------------------|-------|----------|
| <input type="checkbox"/> PARTY AT INTEREST | | Name | | | |
| Old Phone Number | | | New Phone Number | | |
| Old Address | | | New Address | | |
| City | State | Zip Code | City | State | Zip Code |
| Old E-mail Address | | | New E-mail Address | | |

| C. CERTIFICATE OF SERVICE | | |
|---|-----------|------|
| <input type="checkbox"/> I certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, GA 30303-1299 | | |
| Print Name Here | Signature | Date |
| Phone Number | E-mail | |

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).