

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

ANNUAL INSURER UPDATE

In conformity with Title 34, Section 34-9-131 of the Code of Georgia, it is hereby represented that the undersigned applicant has heretofore been licensed by the Insurance Commissioner of Georgia to write workers' compensation insurance, and has complied with the provisions of the laws of the State of Georgia regulating insurance companies, under the provisions of the Georgia Workers' Compensation Act. Send this form, accompanied by current GA Certificate of Authority, to the State Board of Workers' Compensation, 270 Peachtree Street NW, Atlanta, GA 30303-1299.

SECTION A. CORPORATE / ADMINISTRATIVE OFFICE (Licensure, Permit, Assessment Contact)			
Name of Carrier (As it appears on permit)		SBWC ID #	FEIN #
Address		City	State Zip Code
Contact Person	Title	Toll Free Phone Number and Ext	
Primary E-mail Address for Licensure/Assessment		Secondary E-mail Address for Licensure/Assessment	

SECTION B. CLAIMS HANDLING (Please state where Primary Georgia Workers' Compensation Claims are Handled)			
The above-named insurer / self-insurer / group fund has obtained the services of the following individual, firm, or company, as its servicing agent for the administration of workers' compensation claims			
Name of TPA / Servicing Agent			FEIN #
Address		City	State Zip Code
Contact Person	Title	Toll Free Telephone Number and Ext	
Primary E-mail Address for Claims Handling		Secondary E-mail Address for Claims Handling	
Number of Adjusters Handling Claims	Number of Locations/Offices Handling GA Claims		

SECTION C. (If Section A and B are locations outside the State of Georgia, Section C must be completed)			
GEORGIA AGENT MUST be located Georgia and MUST be able to execute payment/have check writing authority.			
Company		Contact Person	Telephone Number and Ext
Mailing Address		City	State Zip Code
E-mail Address		Toll Free Telephone Number and Ext	
The undersigned applicant covenants and agrees with the State Board of Workers' Compensation to be bound in all respects by the Georgia Workers' Compensation Act as embodied in title 34 of the Code of Georgia of 1982, as amended.			
Signed This _____ Day of _____, 20____.			
_____ Name of Company and Person Completing this application			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-651-7839 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).