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

FEIN #	SBWC ID #	Name of Insurer / Self-Insurer / Group Fund		
Mailing Address		City	State	Zip Code
Person Completing this Form	Name of Company	Signature of Person Completing this Form		
Date	Phone Number and Ext	E-mail address		

B. NOTICE OF TERMINATION

TPA / Servicing Agent being Terminated		FEIN #	
Mailing Address	City	State	Zip Code

C. NOTICE OF REPLACEMENT

New TPA / Servicing Agent			FEIN #
Mailing Address	City	State	Zip Code
Contact Name	Title	Telephone Number (toll-free if out-of-State of Georgia)	Fax Number
E-mail Address	Secondary E-mail		**Effective Date of Change**

D. NOTICE OF ADDITION

The above-named Insurer / Self-Insurer / Group Fund has **OBTAINED** the services of the following individual, firm, or company, as an additional TPA/Servicing Agent for the administration of workers' compensation claims.

Name of Additional TPA/Servicing Agent			FEIN #
Mailing Address	City	State	Zip Code
Contact Name	Title	Telephone Number (toll-free if out-of-State of Georgia)	Fax Number
E-mail Address	Secondary E-mail		Effective Date of Change

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. FEIN number for the insurer/self-insurer/group fund
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. Name of insurer/self-insurer/group fund **(do not use acronyms)**
4. Mailing address, city, state, zip code
5. Person completing this form
6. Name of company
7. Signature of person completing this form
8. Date the form is being completed
9. Phone number and extension
10. E-mail address – this will be used by the Board for notifications/legal notices and may be given to the public

Section B

Notice of Termination (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 (mandatory when completing section B)

1. Name of the 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/title – this is the person the Board will contact if needed
5. Telephone 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 will be given to the public
8. Secondary e-mail – if applicable
9. Effective date of the change implemented

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/title – this is the person the Board will contact if needed
5. Telephone 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
9. Effective date of the change implemented