



Instructions

- Please print or type.
• Please check the appropriate box in each section.
• All information must be completed in order for this form to be processed.
• Return this form to your local BWC Customer Service Office as soon as possible.

Form with sections: Injured Worker Information, Old Mailing Address, New Mailing Address. Fields include name, SSN, claim number, date of injury, date of birth, address, city, state, ZIP code, and telephone number.

Please indicate effective date of address change:

I certify the information on this form is true and correct.
Phone number, Cell number, E-mail address

Injured worker signature, Date

BWC USE ONLY: Date V3 Updated, Updated by:
IC USE ONLY: Date CAS Updated, Updated by: