



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, dates, addresses, and ZIP codes.

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: