Bureau of Workers' Compensation

Injured Worker's Change of Address Notification

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.

Injured Worker Information		
Injured worker name		Telephone number ( )
Social Security number	Claim number(s)	
Date of injury	Date of birth	

Old Mailing Address		
Address		Apartment number
City	State	Nine-digit ZIP code

New Mailing Address		
Address		Apartment number
City	State	Nine-digit ZIP code

Please indicate effective date of address change:

Injured worker signature	Date

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

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