

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 Servicing Agent for the administration of workers' compensation claims.			
Name of 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 404-651-7839 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).