

Department of Industrial Relations  
Division of Workers' Compensation  
Office of Benefit Assistance and Enforcement

Workers' Compensation  
Self-Insured Self-Administered Employer  
Report of Changes

**Instructions**

This form is to be completed whenever

- the certificate name changes (section 1)
- there is a new workers' compensation claims manager/contact person (section 2)
- the physical location of the claims administrator changes (section 3 and section 4 if the physical location address is the mailing address)
- the mailing address changes (section 4)
- a new claims administration location is established (section 5)

Send the completed,  
signed and dated form to:

DWC Audit and Enforcement Unit  
P. O. Box 603  
San Francisco, CA 94101

with a copy to:

Self-Insurance Plans  
2848 Arden Way, Suite 105  
Sacramento, CA 95825

For assistance in completing this form or for additional forms, please call (415) 737-3090

Certificate Number:    \_ - \_ \_ \_

Certificate Name: \_\_\_\_\_

**Section 1:**                    New Certificate Name \_\_\_\_\_

**Section 2:**                    Location Code \_\_\_\_\_

New Workers' Compensation Claims Manager/Contact Person Name \_\_\_\_\_

**Section 3:**                    Location Code \_\_\_\_\_

New Physical Location: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

**Section 4:**                    Location Code \_\_\_\_\_

New Physical Location: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

**Section 5:**

Physical Location \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Claims Manager/ Contact Person Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

Signature:

Claims Manager/Contact Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Telephone \_\_\_\_\_

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For DWC Audit and Enforcement Unit Use only

Date that change(s) were recorded on DWC Online system: \_\_\_\_\_

Recorded by: \_\_\_\_\_