

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

**Workers' Compensation  
Adjusting Agency/Third –Party Administrator  
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)
- a new self-insured account is added (section 6)
- a self-insured account is deleted (section 7)
- a new insurance carrier account is added (section 8)
- an insurance carrier account is deleted (section 9)

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: \_\_\_\_\_