NEW YORK STATE | Workers' Compensation Board

Claimant Name and Address Form

DO NOT SEND A COPY OF THIS FORM TO THE BOARD

WCB Case #: _____ Date of Injury/Illness: _____

Claimant Information New

New Last Name: _____ New First Name: _____ MI: ____

New Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

New Phone Number: _____ New Email Address: _____

Claimant Information Previous

Previous Last Name: _____ (if applicable) Previous First Name: _____ (if applicable) MI: ____

Previous Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Previous Phone Number: _____ Previous Email Address: _____

Insurer Information

Claim Administrator Claims (Carrier Case) #: _____

Insurer Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Attorney Information

Attorney R #: _____

Attorney Name: _____

Phone Number: _____ Email Address: _____

Certification of Transmittal of this notice to Insurance Carrier/Self Insured Employer/Employer

I hereby certify that a copy of this notice was transmitted to the insurance carrier, insurer's TPA, self-Insured employer or employer named above.

_____ _____

Attorney's Signature Date

Notice to the Attorney

A copy of this form must be sent to the workers' compensation insurance carrier, self-insured employer or employer.

Notice to Insurer

The appropriate EDI filing should be submitted to the Board to update the claimant's address and/or name in the case file.