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Instructions for Completing the

Notice of Change of Carrier or Adjusting Firm

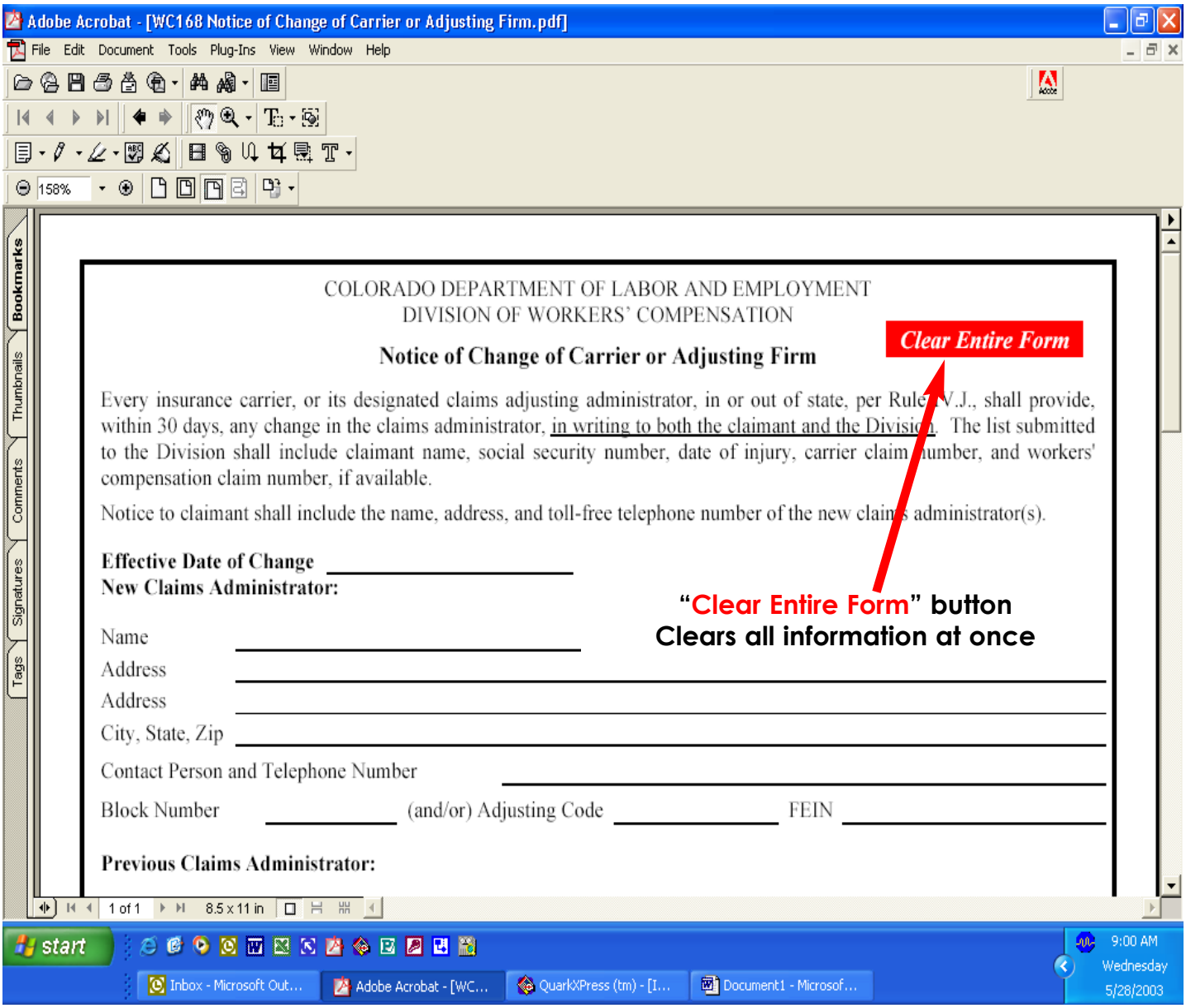
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Effective Date of Change" box (field) and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for SSN and phone number. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. To fill in a check box, click inside the box with your mouse. The "Contact Person and Telephone Number" fields are surrounded by a gray border. Type the information in the first field and tab to the next to enter more information.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Notice of Change of Carrier or Adjusting Firm
Clear Entire Form
Every insurance carrier, or its designated claims adjusting administrator, in or out of state, per Rule V.J., shall provide, within 30 days, any change in the claims administrator, in writing to both the claimant and the Division. The list submitted to the Division shall include claimant name, social security number, date of injury, carrier claim number, and workers' compensation claim number, if available.
Notice to claimant shall include the name, address, and toll-free telephone number of the new claims administrator(s).
Effective Date of Change
New Claims Administrator:
Name
Address
Address
City, State, Zip
Contact Person and Telephone Number
Block Number
(and/or) Adjusting Code
FEIN
Previous Claims Administrator:
1 of 1
8.5 x 11 in
"Clear Entire Form" button
Clears all information at once
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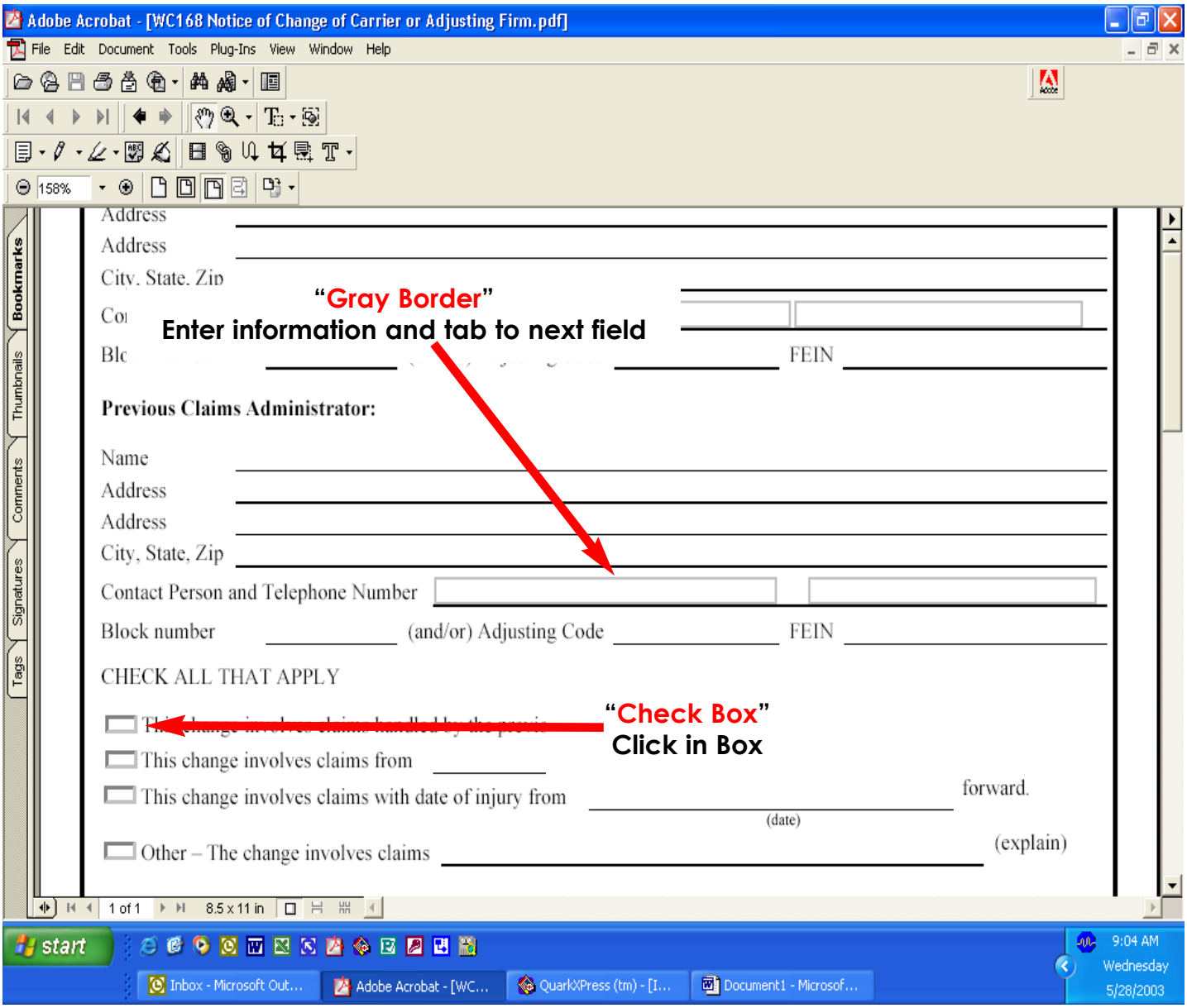
9:00 AM
Wednesday
5/28/2003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File Edit Document Tools Plug-Ins View Window Help
Bookmarks
Thumbnails
Comments
Signatures
Tags
Address
Address
City, State, Zip
"Gray Border"
Enter information and tab to next field
FEIN
Previous Claims Administrator:
Name
Address
Address
City, State, Zip
Contact Person and Telephone Number
Block number
(and/or) Adjusting Code
FEIN
CHECK ALL THAT APPLY
"Check Box"
Click in Box
This change involves claims from
This change involves claims with date of injury from
forward.
(date)
Other – The change involves claims
(explain)
1 of 1
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Wednesday
5/28/2003

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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Clear Entire Form

Notice of Change of Carrier or Adjusting Firm

Every insurance carrier, or its designated claims adjusting administrator, in or out of state, per Rule 5-13(A), shall provide, within 30 days, any change in the claims administrator, in writing to both the claimant and the Division. The list submitted to the Division shall include claimant name, social security number, date of injury, carrier claim number, and workers' compensation claim number, if available.

Notice to claimant shall include the name, address, and toll-free telephone number of the new claims administrator(s).

Effective Date of Change _____

New Claims Administrator:

Name _____

Address _____

Address _____

City, State, Zip _____

Contact Person and Telephone Number _____ _____

Block Number _____ (and/or) Adjusting Code _____ FEIN _____

Previous Claims Administrator:

Name _____

Address _____

Address _____

City, State, Zip _____

Contact Person and Telephone Number _____ _____

Block number _____ (and/or) Adjusting Code _____ FEIN _____

CHECK ALL THAT APPLY

☐ This change involves claims handled by the previous claims administrator.

☐ This change involves claims from _____ (date)

☐ This change involves claims with date of injury from _____ forward.
(date)

☐ Other – The change involves claims _____ (explain)

_____

List all claims that will be handled by a new administrator. To submit this information electronically, you may wish to contact the Division of Workers' Compensation Customer Service Unit at 303.318.8700

Division WC #	Claimant Name	SSN	Date of Injury	Carrier Claim Number

Use additional pages as necessary.

This form has been completed by _____

Signature _____ Date _____ Phone _____

Title _____ Company _____

Clear Entire Form