WORKERS' COMPENSATION COMMISSION

CLAIMANT REQUEST FOR CHANGE OF ADDRESS

This form can be used only to change **the Claimant Address** for **the Claim Number** indicated and cannot be used for other parties in the claim. No filing accepted by email or FAX.

WCC CLAIM NUMBER: _____

CLAIMANT: _____

EMPLOYER: _____

INSURER: _____

NEW ADDRESS

_____
Street

_____ _____ _____
City State Zip Code

PRIOR ADDRESS

_____
Street

_____ _____ _____
City State Zip Code

REQUESTED BY: ◯ CLAIMANT ◯ CLAIMANT'S ATTORNEY

_____ _____
FULL NAME Street Address

_____ _____ _____
City State Zip Code

I hereby certify that on the ____ day of _____ , ____a copy of this Request has been sent to the Workers' Compensaton Commission, all parties and their attorneys.

_____ _____ _____
Signature Date Telephone Number

CLICK HERE TO CLEAR THE FORM

10 East Baltimore Street ● Baltimore, Maryland 21202-1641
410-864-5100 ● Email: info@wcc.state.md.us ●Web: http://www.wcc.state.md.us