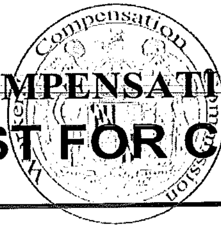

WORKERS' COMPENSATION COMMISSION

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

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