COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT DIVISION OF WORKERS’ COMPENSATION

**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:**

**Employer**

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. 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**

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| --- | --- | --- | --- | --- |
| **Division WC #** | **Claimant Name** | **SSN** | **Date of Injury** | **Carrier Claim Number** |
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**Use additional pages as necessary.**

This form has been completed by

Signature Title

Date Phone Company

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