COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Clear 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 _____ **Employer** _____

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.
- ☐ 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 _____

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