WellSpan Occupational Health

COMPANY CHANGE REQUEST FORM
Please fax the completed form to 717-851-1610

_____ _____
Company Name Number of Employees

COMPANY ADDRESS CHANGE

_____ _____
New Mailing Address Previous Mailing Address

_____ _____
New Billing Address Previous Billing Address

DESIGNATED COMPANY REPRESENTATIVE CHANGE

Choose if applicable: ☐ PPD ☐ Consortium ☐ Driver ☐ Drug ☐ Respirator ☐ PPE ☐ Workers Comp ☐ Other _____

Contact Name and Title	
Replacing (Contact Name)	
Address ☐ Same as mailing	
Phone (include area code)	
Secure fax number	
E-mail address	

Choose if applicable: ☐ PPD ☐ Consortium ☐ Driver ☐ Drug ☐ Respirator ☐ PPE ☐ Workers Comp ☐ Other _____

Contact Name and Title	
Replacing (Contact Name)	
Address ☐ Same as mailing	
Phone (include area code)	
Secure fax number	
E-mail address	

WORKERS COMPENSATION POLICY CHANGE

Workers Compensation Insurance Company (Full name)

_____

Workers Compensation Insurance Company full address and phone number

_____

Policy Number and Expiration Date _____

Self Insurance? _____Yes _____No

Third Party Administrator if Self Insurance _____

_____ _____
Company Authorized Representative Signature Date