COMPANY INFORMATION FORM
Please fax the completed form to 717-851-1650

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** _____