

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
 STANDARD COVERAGE FORM
 GROUP SELF-INSURANCE FUND MEMBERS
 PLEASE TYPE

| SECTION A - INFORMATION ABOUT THE FUND MEMBER | FILE SEPARATELY FOR EACH NAME |
|---|---|
| 1. Insured Member (Corporate Name): | 5. dba (Doing Business As, if applicable) |
| 2. Corporate Address: | 6. dba Address (Location): |
| 3. Type of Business: | 7. Franchise/Store # (if applicable): |
| 4. EFFECTIVE DATE: (Original Effective Date of Fund Member) | 8. Policy Number: |

SECTION B - CHANGES TO ORIGINAL POLICY - ACTION REQUIRED

1. _____ ADD dba Name: _____ Effective: _____
2. _____ ADD Location: _____ Effective: _____

3. _____ CANCEL Corporate Name: _____ Effective: _____
4. _____ CANCEL dba Name: _____ Effective: _____
5. _____ CANCEL Location: _____ Effective: _____

6. _____ REINSTATE: Name(s) in Section A Effective: _____

- NAME CHANGE: (New Name Should Appear in Section A)
7. _____ Old Corporate Name: _____ Effective: _____
8. _____ Old dba Name: _____ Effective: _____

- ADDRESS CHANGE (New Address Should Appear in Section A)
9. _____ Old Corporate Address: _____
10. _____ Old dba Name: _____

SECTION C - INFORMATION ABOUT THE GROUP FUND AND SERVICING AGENT

1. Group Self-insurance Fund Name: _____
2. Name and Address of Servicing Agent: _____

3. Name and Phone Number (include extension if applicable) of Person Completing Form:

| | | |
|------|--------------|-----------|
| Name | Phone Number | Extension |
|------|--------------|-----------|

DETAILED INSTRUCTIONS ON BACK

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

Use this form to:

To notify Board of coverage of new fund member, complete Sections A and C.
To notify Board of changes/activity, (as listed in Section B) complete A, B, and C.

Mail to: Coverage Section
State Board of Workers' Compensation
270 Peachtree Street, NW
Atlanta, GA 30303-1299

INSTRUCTIONS FOR COMPLETING FORM WC-11

SECTION A:

1. ENTER COMPLETE CORPORATE NAME.
2. ENTER ADDRESS OF CORPORATE OFFICE.
3. ENTER TYPE OF BUSINESS (I.E. general contractor, retail sales, restaurant, landscaping, etc.).
4. ENTER ORIGINAL EFFECTIVE DATE OF INSURED MEMBER.
5. ENTER DOING BUSINESS AS (dba) NAME WHEN DIFFERENT FROM CORPORATE NAME. COMPLETE SEPARATE FORM WC-11 FOR EACH DIFFERENT (dba) NAME.
6. ENTER ADDRESS OF (dba) LOCATION (IF MORE THAN ONE LOCATION, USE SEPARATE FORM WC-11).
7. ENTER HERE IF A FRANCHISE OR "CHAIN" USES A STORE NUMBER TO IDENTIFY A SPECIFIC LOCATION.
8. ENTER POLICY NUMBER ISSUED WHEN INSURANCE IS PURCHASED.

SECTION B: CHECK EXACT ACTION(S) BEING TAKEN AND GIVE EFFECTIVE DATE OF ACTION.

1. ADD DOING BUSINESS AS (dba) NAME AS SHOWN IN SECTION A - (5).
2. ADD LOCATION ADDRESS AS SHOWN IN SECTION A - (6).
3. CANCEL CORPORATE NAME AS IN SECTION A - (1).
4. CANCEL DOING BUSINESS AS (dba) NAME AS SHOWN IN SECTION A - (5).
5. CANCEL LOCATION ADDRESS AS SHOWN IN SECTION A - (6).
6. EFFECTIVE DATE OF REINSTATEMENT.
7. CORPORATE NAME PRIOR TO NAME CHANGE.
8. DOING BUSINESS AS (dba) NAME PRIOR TO NAME CHANGE.
9. OLD CORPORATE ADDRESS PRIOR TO ADDRESS CHANGE.
10. OLD DOING BUSINESS AS (dba) ADDRESS PRIOR TO ADDRESS CHANGE.

SECTION C:

1. COMPLETE GROUP SELF-INSURANCE FUND NAME - DO NOT USE ABBREVIATIONS OR INITIALS.
2. NAME AND ADDRESS OF THIRD PARTY ADMINISTRATOR PROCESSING CLAIMS.
3. NAME AND PHONE NUMBER (WITH EXTENSION) OF PERSON COMPLETING FORM - DO NOT USE INITIALS.