

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

<b>SECTION A - INFORMATION ABOUT THE FUND MEMBER</b>	<b>FILE SEPARATELY FOR EACH NAME</b>
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
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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-1 1

#### 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.