



CHANGE OF NAME, ADDRESS, OR CONTACT INFORMATION

Please use this form to advise WorkSafeBC of a change in your name or contact information. Name, address, or contact information changes will not be accepted without receipt of this form or other written notification. Supporting documentation is also required for name change (*see below).

Please mail or fax this form to WorkSafeBC. Until properly notified, payments will continue to be made to you based on name and address in our records.

CLAIMS CALL CENTRE

Phone 604 231-8888
Toll-free 1 888 967-5377
M-F, 8:00 a.m. to 4:30 p.m.

FAX

604 233-9777
Toll-free **1 888 922-8807**

MAIL

WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

If you are also receiving pension payments from us, please check here

WorkSafeBC claim number

Customer Care number

Your contact information prior to changes

Title <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>	Worker last name	First name	Middle initial
Address line 1		Preferred first name	
Address line 2		City	Province/State
Home phone number <i>(please include area code)</i>		Country <i>(if not Canada)</i>	Postal code/Zip
Business phone number <i>(please include area code)</i>	Business ext.	Business fax number <i>(please include area code)</i>	Home e-mail address
Date of birth <i>(yyyy-mm-dd)</i>	Social insurance number	Personal health number <i>(BC CareCard)</i>	

Name change (complete only the parts that have changed)

Title <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>	New last name	New first name	Middle initial
<p>* You must provide documentation (do not send originals). Enclosed is a copy of my</p> <p>Change of name certificate <input type="checkbox"/> Marriage certificate <input type="checkbox"/> Birth certificate <input type="checkbox"/> Citizenship card <input type="checkbox"/> Other <i>(please specify)</i> <input type="checkbox"/></p>			

Address change (complete only the parts that have changed)

New address line 1	City	Province/State
New address line 2	Country <i>(if not Canada)</i>	Postal code/Zip
New home e-mail address		

Phone number change (complete only the parts that have changed)

New home phone number <i>(please include area code)</i>		
New business phone number <i>(please include area code)</i>	New business ext.	New fax number <i>(please include area code)</i>

Certification

I confirm the information on this form is correct and complete.		
Signature	Date <i>(yyyy-mm-dd)</i>	Change effective date <i>(yyyy-mm-dd)</i>

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.

