GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Workers'
Chief Risk Officer

Public Sector
Compensation Program

FORM 16 –EMPLOYEE CHANGE OF ADDRESS

Use this form to notify the Public Sector Workers' Compensation Program a change in your address.

CLAIMANT INFORMATION

Name: _____ **Telephone:** _____

Claim Number: _____ **Claims Examiner:** _____

OLD ADDRESS

Street Address (No P.O. Boxes) APT, STE, RM (if applicable)

City State Zip Code

Telephone E-mail Address

Mobile Phone Work Phone

NEW ADDRESS

Street Address (No P.O. Boxes) APT, STE, RM (if applicable)

City State Zip Code

Telephone ☐ No Change E-mail Address ☐ No Change

Mobile Phone ☐ No Change Work Phone ☐ No Change

Please update my address information per the information above. I certify that the foregoing information is true, correct and accurate to the best of my knowledge.

Print Name Signature Date

Claimant **MUST** file this claim for disability by mail, e-mail, or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 8:30 a.m. and 5:00 p.m. at:	**Office of Risk Management** **One Judiciary Square** **441 Fourth Street, N.W., Suite 800 South** **Washington, DC 20001-2714** **Phone: (202) 442 HELP (4357)** **Email: wcsecure@dc.gov**