State of Wisconsin
Worker's Compensation - Self-Insurance
Claims Handling Change Form

Each section of this form must be completed in its entirety when an employer changes their claims handling office (a/k/a third party) administrators (TPA). *Anytime a change occurs, a separate form should be submitted to DWD*.

Employer Information

Legal name of employer	FEIN

Claims Handling Office / Third Party Administrator (TPA) Must be completed when changing Claims Office/ TPA

Claims Handling Office Legal Name	Claims Handling Office FEIN

Claims Handling (TPA Address) Information
Note: Each legal entity can have only one claims handling address, per Wisconsin Statute

Address line 1	Address line 2
City, State, Zip Code	

Claims Handling Person

Prefix (Mr., Ms., Dr., Atty. Etc.)	Name	
Title	800 telephone number	Telephone number
Fax number	E-mail address	

Effective date of the change:

☐ The above claims handling office will handle all past and future claims of employer. **(Dept. strongly encourages this option.)**

☐ The above claims handling office will handle only future claims on a going forward basis, beginning: .

Should the same changes be made to other entities, such as current and/or former self-insured entities?
☐ Yes ☐ No
(If YES, please *attach* a list of these entities that should be changed. The list should include the name and FEIN of each entity.) **If the change is different for each entity, then a separate form needs to be completed for each entity describing the type of change desired.**

Authorized Signature _____

Print Name, Position _____

Company _____

Date Signed _____

Please return this completed document to:
State of Wisconsin, Department of Workforce Development
Attention: Self Insurance Analysts
PO Box 7901
Madison, WI 53707
Or e-mail the completed document to: WCSELFINS@dwd.wisconsin.gov