State of Oregon
Workers' Compensation Division
350 Winter St NE, Salem OR 97309-0405

INSURER'S NOTIFICATION OF PLACE OF BUSINESS IN OREGON

INSURER'S NAME: ____

FEIN NO.:________________ NAIC NO.:_________________ NCCI NO:________________________

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GROUP NAME:____

GROUP NAIC NO.:____

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LOCATION & MAILING ADDRESS OF HOME OFFICE:

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____

TELEPHONE NO.:______________________________FAX NO.:_________________________________

EMAIL ADDRESS:____

LOCATION & MAILING ADDRESS OF OREGON OFFICE(S):

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NAME, TELEPHONE NO. & E-MAIL ADDRESS of Underwriting Manager at this location:

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NAME & TELEPHONE NO. & E-MAIL Address of Claims Manager at this location:

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NAME & LOCATION OF SERVICE COMPANY (IF ANY) IN OREGON:

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NAME & TELEPHONE NO. & FAX NO. & E-MAIL ADDRESS OF INSURER'S AUTHORIZED REPRESENTATIVE AT THIS LOCATION____

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A COPY OF THE AGREEMENT BETWEEN THE INSURER & THE SERVICE COMPANY (IF ANY) MUST ACCOMPANY THIS NOTICE!

IF ITS PLACE OF BUSINESS, OR THAT OF ITS SERVICE COMPANY IS CHANGED, THE INSURER SHALL NOTIFY THE WORKERS' COMPENSATION DIVISION OF THE NEW LOCATION AND MAILING ADDRESS OF THE PLACE OF BUSINESS WITHIN 30 DAYS OF THE CHANGE.

INSURER ___________________________

BY _________________________________

DATE _________________________________ TITLE _____________________________