



Bureau of Workers' Compensation

Injured Worker's Change of Contact Information (C-77)

Claim number(s)

Instructions

Submit this form to BWC in one of the following ways.

Fax: 1-866-336-8352

Mail: BWC Mail Processing Center
Attn: Claims Services
30 W. Spring St.,
Columbus, OH 43215-2256

Important: If you fax, or mail the form to BWC, be sure to sign and date the form.

I am reporting the following changes (check all that apply).

Change of: Name Address (mailing and/or home) Phone number (cell and/or home) Email address

Effective date of change _____

Injured worker name		
Old name		Date of birth
New name		Date of birth
Mailing address		
Old mailing address		
City	State	ZIP code
New mailing address		
City	State	ZIP code
Home address		
Old home address		
City	State	ZIP code
New home address		
City	State	ZIP code
Phone number		
Old phone number	<input type="checkbox"/> Home <input type="checkbox"/> Cell	New phone number <input type="checkbox"/> Home <input type="checkbox"/> Cell
Email address		
Old email	New email	
Injured worker signature		
I have provided accurate and complete information. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.		
Signature		Date