

**NORTH CAROLINA DEPARTMENT OF INSURANCE**  
**Individual Employers Self-Insurance for Workers' Compensation**  
**Individual Changes in Name, Address, and Business Structure**

Financial Analysis & Receivership Division  
Special Entities Section  
Self-Insured Workers' Compensation  
1203 Mail Service Center  
Raleigh, NC 27699-1203

**Under NCGS 97-180(e), every self-insurer shall report promptly to the Commissioner changes in the names and addresses of the businesses if self-insures or intends to self-insure as well as changes in business structure including its divisions, subsidiaries, affiliates, and internal organization. Any changes shall be reported in writing to the Commissioner within 10 days of the effective date of change.**

Notification Date (mm/dd/yyyy): \_\_\_\_\_  
Employer Code: \_\_\_\_\_  
Employer Name: \_\_\_\_\_

**EMPLOYER OR SUBSIDIARY NAME AND ADDRESS CHANGE**

New Employer/Subsidiary Name: \_\_\_\_\_  
Previous Employer/Subsidiary Name: \_\_\_\_\_  
Effective Date of Change (mm/dd/yyyy): \_\_\_\_\_

**New Physical Address**

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Company Contact: \_\_\_\_\_  
Contact's Telephone Number: \_\_\_\_\_

**New Mailing Address**

Street Address/Post Office Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Company Contact: \_\_\_\_\_  
Contact's Telephone Number: \_\_\_\_\_

**THIRD PARTY ADMINISTRATOR (TPA) CHANGE**

New TPA: \_\_\_\_\_

Previous TPA: \_\_\_\_\_

Effective Date of Change (mm/dd/yyyy): \_\_\_\_\_

**NORTH CAROLINA SUBSIDIARY ADDITIONS**

Name of Acquired Subsidiary: \_\_\_\_\_

Date of Acquisition (mm/dd/yyyy): \_\_\_\_\_

Percentage Ownership: \_\_\_\_\_

Total Uninsured Loss Claims: \_\_\_\_\_

Requested Date to Self-Insure (mm/dd/yyyy): \_\_\_\_\_

**NORTH CAROLINA SUBSIDIARY DELETIONS**

Name of Disposed Subsidiary: \_\_\_\_\_

Effective Termination Date (mm/dd/yyyy): \_\_\_\_\_

**MERGERS AND ACQUISITIONS**

Effective Date of Merger/Acquisitions (mm/dd/yyyy): \_\_\_\_\_

Name of Acquired Company: \_\_\_\_\_

Name of Surviving Company: \_\_\_\_\_

Surviving Company's Fiscal Year End (mm/dd/yyyy): \_\_\_\_\_

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Signature of Authorized Company Officer: \_\_\_\_\_

Title of Authorized Company Officer: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_