Matt Bevin
Governor

Jenean Hampton
Lt. Governor

Kentucky Labor Cabinet
Division of Workers' Compensation Funds
657 Chamberlin Avenue
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Phone: (502) 564-5467
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Derrick K. Ramsey
Secretary

William Emrick
Acting Commissioner

Judith Erickson
Director

ADDRESS CHANGE REQUEST FORM

Please fill out all information completely. Sign, date and mail form to: Kentucky Labor Cabinet, Division of Worker's Compensation Funds, 657 Chamberlin Avenue, Frankfort, KY 40601. Please allow up to 4 weeks for the address change to take effect.

CLAIM NUMBER: _____
CLAIMANT'S NAME: _____SS#_____
OLD ADDRESS: _____
_____
NEW ADDRESS _____
_____
TELEPHONE NUMBER: ( ) _____
SIGNATURE OF CLAIMANT: _____ **DATE**: _____

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF _____)

Subscribed and sworn before me, I _____, a Notary Public, in and for the County and State above, do hereby declare that the Affiant, _____did appear personally before me and furnish adequate identification of identity and stated that _____(he/she) did sign this document of Claimant's own free will, on this the _____ day of _____, 20__.

(AFFIX SEAL)

_____
Notary Public

My Commission expires: _____