Form CMB-ADD-3
Change of Address for Continuation of Benefits
Revised August 2018

KENTUCKY LABOR CABINET

Department of Workers' Claims
500 Mero Street, 3rd Floor
Frankfort, KY 40601

CHANGE OF ADDRESS

WORKERS' COMPENSATION CLAIM NUMBER: _____

CLAIMANT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER/GREEN CARD NUMBER: _____

CURRENT MAILING ADDRESS: _____

EMAIL ADDRESS (IF APPLICABLE):_____

TELEPHONE NUMBER (OPTIONAL):_____

I certify under penalty of perjury that the foregoing information is true and accurate.

CLAIMANT SIGNATURE: _____

DATE: _____

IF SUBMITTED BY EMPLOYER, MEDICAL PAYMENT OBIGOR OR ANY PERSON OTHER THAN CLAIMANT:

SUBMITTING ENTITY NAME: _____

NAME AND TITLE OF PERSON COMPLETING FORM:

_____

SIGNATURE: _____

DATE: _____