

INSURER'S NOTICE OF NAME OR ADDRESS CHANGE

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, Michigan 48909

INSTRUCTIONS: SEE REVERSE SIDE

SECTION A

Employer Federal ID Number	Name of Business
Policy Number	

SECTION B

FORMER NAME/ADDRESS OF BUSINESS	CURRENT NAME/ADDRESS OF BUSINESS
Name of Business	Name of Business
Address (Street Number and Name)	Address (Street Number and Name)
City, State, ZIP Code	City, State, ZIP Code
Effective Date of Change	

SECTION C

PLEASE LIST BELOW ADDITIONAL NAMES AND/OR ADDRESSES FOR THE FEDERAL ID NUMBER LISTED IN SECTION A	
Name of Business	Name of Business
Address (Street Number and Name)	Address (Street Number and Name)
City, State, ZIP Code	City, State, ZIP Code
Effective Date of Change	Effective Date of Change
Reason for Change	Reason for Change
Name of Business	Name of Business
Address (Street Number and Name)	Address (Street Number and Name)
City, State, ZIP Code	City, State, ZIP Code
Effective Date of Change	Effective Date of Change
Reason for Change	Reason for Change

SECTION D

Name of Insurance Company	NAIC Carrier ID Number (9 digits)
ZIP Code of Issuing Office	Telephone Number (including area code)
Authorized Signature	Date

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act of 1969 418.625; R408.41
Completion: Mandatory
Penalty: Failure to file is punishable under MCLA 418.631

Purpose of Form WC-403

To notify the Michigan Workers' Compensation Agency of a name and/or address change of an employer. (Effective April 1, 1994, this will replace the procedure of filing Form 401 and then a Form 400 showing a name change. Do not file a Form 401 terminating the old name.)

To notify the agency of an addition or deletion of a division of the employer.

To notify the agency of a name or address change of a division of an employer.

INSTRUCTIONS FOR COMPLETION

SECTION A

Employer's Federal Identification Number	Enter the employer's Federal Identification Number. This is a 9-digit number. If an individual (sole proprietor) does not have a Federal Identification Number, the Social Security Number of the individual will be accepted.
Name of Business	Enter complete name of business, including assumed name.
Policy Number	Complete number.

SECTION B

This section will be used to change the name and/or address of the employer. If used for a name change, this section must include the previous name of the employer and the new name of the employer.

Name of Business	Enter complete name of the employer.
Address	The complete address of the business, including city, state, and ZIP code, must be identified.
Effective Date of Change	Date that the name and/or address change is effective.

SECTION C

This section will allow for the addition, deletion, change of name, or change of address of a division. A division is an operation of the employer that operates under the same Federal Identification Number but under an assumed name. If used for a name change to a division, then this section must include previous name of the employer and the new name of the employer.

Name	Enter the complete name of the division.
Address	The complete address of the business, including city, state, and ZIP code, must be identified. Use street address, not post office box number.
Effective Date of Change	The date that the addition, deletion, or change of name and/or address is effective.
Reason for Change	Addition of a division, deletion of division; e.g. due to sale of division, division no longer in business, etc.; or change; e.g. name change, address change, etc.

SECTION D

This section will identify the insurance company making the change.

Name of Insurance Company	Complete name of insurance company.
NAIC Carrier ID No.	National Association of Insurance Commissioners' (NAIC) ID number (5 digits) followed by the group number (4 digits) of the insurance company.
Telephone Number	Telephone number of office filing the form.
ZIP Code of Issuing Office	Show the complete ZIP code for the insurance company office issuing this form.
Authorized Signature	Must have an original signature in black or blue ink. Typed signature is not acceptable. Include the date the form was signed.