STATE OF NEW HAMPSHIRE
Department of Labor
P.O. Box 2080
Concord, NH 03302-2080
(603) 271-3175

SUPPLEMENTAL NOTICE OF INFORMATION REGARDING WORKERS' COMPENSATION INSURANCE COVERAGE

* * * THIS SECTION IS **ALWAYS** REQUIRED * * *

1 = ADDING OR DELETING LOCATION 2 = CHANGE INFORMATION ON THE PRIMARY LOCATION

1. Type of Action:__________________

Effect. Date of Action: __________________ Original Employer Identification #:_______________________

Original Name of Business:____

* * * THIS SECTION IS **ALWAYS** REQUIRED FOR CARRIER INFORMATION * * *

2. Carrier Phone: _____________________________________

Carrier Name: _______________________________________ Carrier ID Number: _______________

* * * THIS SECTION IS FOR MAKING PRIMARY LOCATION CHANGES ONLY * * *

3. CHANGE

Employer Identification #:_____________________________ No. of Employees:___________

Primary Name:____

Secondary Name:____

Mailing Address: ____

City & State: _______________________________________ Zip: ____________________

NH Business Location: _________________________________ Zip: ____________________

Change type of Organization to:________

1 = INDIVIDUAL 2 = PARTNERSHIP 3 = CORPORATION
4 = ESTATE 5 = PROFESSIONAL ASSOCIATION 6 = GOVERNMENT
7 = RELIGIOUS 8 = LIMITED LIABILITY CO. 9 = OTHER

Agent:____ Phone #:________________
(NAME AND ADDRESS)

*** THIS SECTION IS REQUIRED WHEN ADDING OR DELETING A SECONDARY LOCATION***

4. Location: _____________________ A=ADD D=DELETE

Location Name: ____

Business Address: ____

City & State: ____ Zip: _______________

No. of Employees: ____________

Form 6WC-S (Rev. 3/13)