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Claim Reporting
1-800-MEMICWC

Injured Worker Change of Address Request Form

Please complete the following information and return to MEMIC.

Your Name: _____

MEMIC Claim No.: _____ Last 4 Digits of Social Security No.: _____

Old Address

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ - _____ - _____

New Address

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ - _____ - _____

Signature

Date