ACCG Insurance Programs

2023 CONTACT FORM

GROUP SELF-INSURANCE WORKERS' COMPENSATION FUND

[ACCG-GSIWCF / Workers' Compensation Program]

I hereby appoint the **following contacts** for _____
(Name of Organization)

_____ _____
Signature of County Chairman or Executive Director for Authority — Date

- The appointed **ACCG–GSIWCF Insurance Contact** is _____
(Insurance Contact receives invoices & renewals for workers' compensation)

Position_____Email:_____
If there is a change in the insurance contact, please advise if the previous contact is still affiliated with the county for the ACCG database to be current and accurately maintained. ☐ Yes ☐ No

- The appointed **ACCG–GSIWCF Safety Coordinator** is _____
(Safety Coordinator is responsible for the Safety Program)

Position_____Email:_____
If there is a change in the safety coordinator, please advise if the previous contact is still affiliated with the county for the ACCG database to be current and accurately maintained. ☐ Yes ☐ No

- The appointed **ACCG–GSIWCF Claims Contact** is _____
(Claims Contact is responsible for reporting workers' compensation claims / Additional Claims Contacts may be listed on reverse side)

Position_____Email:_____

- The **ACCG–GSIWCF Payroll Audit Contact** is _____
(Audit Contact receives audit notifications & provides requested documents for worker's compensation audit)

Position_____Email:_____

Please EMAIL completed Contact Form to accginsurance@accg.org or FAX 404-522-1897