2026 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