ADDENDUM TO PETITION FOR BENEFIT DETERMINATION **FOR MULTIPLE EMPLOYERS**

Employee Name_____ **Date of Injury**_____

For claims with **multiple employers for the same injury and date of loss**, please list all possible employers and carriers. A copy of this addendum and the petition for benefit determination must be sent to all parties or their attorneys. You must also indicate how you sent all parties or their attorneys a copy of this form.

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*For BWC Use Only: State File No.*_____*RFA No.*_____*Docket No.*_____

Additional Employer's Name _____

Mailing Address _____ City _____ State_____ ZIP_____

Phone_____Fax_____Email_____

Employer Contact Person_____Email_____

Service by: ☐By Hand ☐Mail ☐ Facsimile ☐Email Service Sent to: _____

Employer Attorney _____ BPR # _____

Address _____ City _____ State____ ZIP _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Service by: ☐By Hand ☐Mail ☐ Facsimile ☐Email Service Sent to: _____

Insurance Company _____

Third Party Administrator: _____

Adjuster Name: _____Email_____

Mailing Address: _____ City _____ State____ ZIP _____

Phone_____Fax_____Ins. Claim# _____

Service by: ☐By Hand ☐Mail ☐ Facsimile ☐Email Service Sent to: _____

Need to list more employers? Access another copy of this form.