CC-FORM-7

Send original to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

This space for Commission Use only

DESIGNATION OF SERVICE AGENT

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Consistent with Workers' Compensation Commission Rule 810:10-1-11, once a claim for compensation (CC-Form-3, CC-Form-3A or CC-Form-3B) is filed, the Commission shall send all notices and correspondence to the designated agent of the insurance carrier, individual own risk employer or group self-insurance association, until an entry of appearance is filed as provided by Commission Rule 810:10-1-10. When the claimant files a claim for compensation (CC-Form-3, CC-Form-3A or CC-Form-3B), the Commission shall email a file-stamped copy of the claim form bearing the assigned file number to a single service agent of the self-insured employer, group self-insurance association, insurance carrier or CompSource Oklahoma which shall be designated on a CC-Form-7 and filed with the Commission. The Commission shall send all notices and correspondence to the service agent until an entry of appearance or notice of substitution of attorney is filed pursuant to Rule 810:10-1-11. If no service agent is designated on the CC-Form-7, notices and correspondence shall be sent to the:

1. Signatory on the self-insurance application, if the insurer is an individual own risk employer;
2. Administrator of the group self-insurance association, if the insurer is a group self-insurance association;
3. Person designated to receive notice of service of process for an insurer as provided in 36 O.S., § 621, if the insurer is a foreign or alien insurance carrier; or
4. Service agent on file with the Oklahoma Secretary of State, if the insurer is a domestic insurance carrier.

If the employer is uninsured or the Commission cannot determine insurance coverage, notices and correspondence shall be sent to the employer at the address supplied by the claimant on the claim for compensation form. If the notice is returned to the Commission because the claimant supplied the wrong address for the employer, the Commission shall so inform the claimant. The claimant has the obligation of providing the Commission with the proper address so notices and correspondence can be sent to the employer.

The following information is required and must be amended whenever a change of service agent is made.

Please check (✓) the appropriate box below

Name of: ☐ Carrier ☐ Individual Own Risk Employer ☐ Group Self-Insurance Association ☐ Qualified Employer

Home office mailing address: City State Zip

Street Address, if different from mailing address: Phone Number

Designated Service Agent

Name of Individual or Business:

Name of contact person, if the service agent is a business: E-mail:

Mailing address: City State Zip

Street Address, if different from mailing address: Phone Number

_____ Signed this _____ day of _____, _____
Signature

I HEREBY CERTIFY THAT THIS DOCUMENT WAS MAILED TO THE WORKERS' COMPENSATION COMMISSION ON:

Prepared by _____

_____, _____.

Title _____

Revised 12-18-14