MISSISSIPPI WORKERS' COMPENSATION NOTICE OF COVERAGE

1. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and (select one) (has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer), or (maintains workers' compensation insurance coverage with the following:)

_____

(Name of insurance carrier or self-insurance group)

_____

_____

(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

_____

(Name of third party claims administrator or claims office)

_____

_____

(address & phone number)

III. This workers' compensation coverage is effective for the following period:

_____ to _____

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

_____

(Name of employee's contact person)

_____

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

2001 M.W.C.C. Notice of Coverage Form

PRINT