MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. 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 employer 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.

COMPENSACIÓN AL TRABAJADOR DE MISSISSIPPI

NOTIFICACIÓN DE COBERTURA

I. Por favor tome nota que su Empleador está en cumplimiento con los requisitos de la Ley de Compensación al Trabajador de Mississippi, y **[seleccione uno] [**ha sido aprobado por la Comisión de Compensación al Trabajador de Mississippi para actuar como asegurador de sí mismo**]**, o **[**mantiene seguro de compensación al trabajador con el siguiente:**]**

_____
(Nombre del asegurador o grupo de seguro propio)

_____

_____
(dirección y número de teléfono)

II. Los reclamos individuales de compensación al trabajador serán entregados y procesados por:

_____
(Nombre del administrador de reclamos de terceros u oficina de reclamos)

_____

_____
(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:
_____ hasta _____.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

_____
(Nombre de la persona de contacto del empleador)

_____
(Título y departamento o división)

V. Por favor tenga presente que cualquier persona que intencionalmente hace cualquier declaración o representación falsa o engañosa con el propósito de obtener o retener erróneamente cualquier beneficio o pago bajo la Ley de Compensación al Trabajador de Mississippi puede ser acusado de infracción de Miss. Code Ann. §71-3-69 (Rev. 2000) y al ser condenado será sujeto a las penas provistas en ella.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)

☐ FEMALE (F)

☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)

☐ MARRIED (M)

☐ SEPARATED (S)

☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐

MINOR: BY EMPLOYER (1) ☐

MINOR CLINIC/HOSP (2) ☐

EMERGENCY CARE (3) ☐

HOSPITALIZED > 24 HRS (4) ☐

FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

Post Office Box 5300, Jackson, Mississippi 39296-5300

EMPLOYER'S NOTICE OF CONTROVERSION

MWCC FILE NUMBER
CARRIER FILE NUMBER

EMPLOYEE CLAIMANT			SOC. SEC. NO.			NATURE OF INJURY
ADDRESS			DATE OF BIRTH	AGE	SEX	
CITY	STATE	ZIP	INJURY DATE			

EMPLOYER	INSURANCE CARRIER
_____	_____
_____	_____
ADDRESS	ADDRESS
_____	_____
CITY STATE ZIP	CITY STATE ZIP

Pursuant to Section 71-3-37(4) of the Mississippi Workers' Compensation Act, the above named employer controverts the referenced employee's right to workers' compensation upon the following grounds:

I hereby certify that a copy of this notice has been served, by mail or personal delivery, to the above named employee at the most current address which can be determined by diligent inquiry or to his or her attorney, if represented.

Dated: _____

_____
Signature of Employer/Carrier Representative

_____
Title

_____
Address

_____
City State Zip

Telephone number: _____

MWCC Form B-52 (1993)