MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirement of the Mississippi Workers' Compensation Law and maintains workers' compensation insurance coverage with the following:

____
(Name of insurance carrier of self-insurance group)

____

____
(Phone: ______________)

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

____
(Name of insurance carrier of self-insurance group)

____

____
(Phone: ______________)

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 of to the person listed below:

____
(Name of employer or contact person)

____
(Title of Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purposes 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.