MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

Work	ssippi Workers' Co	ice that your Employer is in compliance with the requirements of the empensation Law, and [select one] [has been approved by the Mississippi Commission to act as a self-insurer], or [maintains workers' compensation of the following:]
msur	ance coverage with	(Name of insurance carrier or self-insurance group)
II.	Individual work	(address & telephone number) ers' compensation claims will be submitted to and processed by:
		(Name of third party claims administrator or claims office)
		(address & phone number)
III.		compensation coverage is effective for the following period: to
IV.	All job related in visor, or to the per	juries or illnesses should be reported as soon as possible to your immediate son listed below:
		(Name of employer contact person)
		(Title & Department/Division)
V.	Please be advise	ed 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