ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Workers' Compensation claims on behalf of National Liability & Fire Insurance Company.

ACA professionals are experienced in Workers' Compensation Law. Please feel free to call our office with any questions you may have regarding your Workers' Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with you to accomplish these goals.

You, the employer, are a vital part of making this happen and listed below are some things you can do:

Review the attached list of Frequently Asked Questions.

1. Report all work related injuries to ACA as soon as you are aware of them. Our toll-free fax number is **1-800-988-4722.**
2. You may report all work-related injuries to ACA by email at **claims@acaworkcomp.com**, or call **1-800-388-6268** for assistance reporting a claim.
3. Refer all medical authorization requests to ACA.
4. Communicate with your employee and ACA throughout the claim.
5. Have some light duty work available for restricted duty.
6. Advise ACA when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best Regards,

Associated Claims Administrators

Mississippi Workers' Compensation Commission
MISSISSIPPI WORKERS' COMPENSATION FACTS

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is essentially a no-fault insurance plan mandated by State law, supervised by the Workers' Compensation Commission and paid for entirely by employers. The Workers' Compensation Law was enacted by the Legislature in 1948 to guarantee the payment of certain medical and wage loss benefits to persons injured on their job. As part of this Law, the Workers' Compensation Commission, with its office in Jackson, MS, was established to supervise and monitor claims which arise under the Law. An employer covered by the Law is required to secure the payment of workers' compensation benefits to its employees by purchasing workers' compensation insurance from an insurance company or by obtaining approval from the Commission to self-insure.

WHO IS COVERED?

Most working Mississippians are protected by the Workers' Compensation Law, but there are exceptions. All employers with five (5) employees regularly employed are required to provide workers' compensation insurance coverage. If the employer has less than five (5) employees, workers' compensation coverage is not mandatory but may be provided voluntarily by the employer. Domestic and farm labor, and employees of non-profit fraternal, charitable, religious or cultural organizations are not covered under the Law unless coverage is provided voluntarily by the employer. The Workers' Compensation Law likewise does not apply to federal employees or certain transportation and maritime employments covered by federal compensation laws. Finally, independent contractors are ordinarily excluded from coverage although special protection is given to employees of subcontractors.

WHAT IS COVERED?

Any injury, however slight or serious, is covered if it arises out of the course and scope of employment. Occupational illnesses and diseases are also covered if job-related, as are work related deaths.

WHEN DOES COVERAGE BEGIN?

The worker is covered and eligible for benefits as soon as he or she begins employment. There is no waiting period or minimum earnings requirement.

WHAT MUST AN INJURED WORKER DO IN THE EVENT OF INJURY?

In the event of an injury, you should immediately notify your supervisor or other person designated by your employer. Prompt and accurate reporting is essential. Your employer is then required to make a report of the injury and notify its insurance company and/or the Workers' Compensation Commission. An injured employee should try to give the employer notice of the injury within 30 days. If no disability benefits are paid to the injured worker by the employer or carrier within two (2) years of the date of injury, then the right to any and all benefits is barred unless the employee files a claim with the Commission during this two (2) year period. This is what is known as the two (2) year statute of limitations.

PLEASE BE ADVISED:

"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 Workers' Compensation Law] is guilty of a felony and on conviction thereof may be punished by a fine not to exceed Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or by imprisonment not to exceed three (3) years, or by both fine and imprisonment."

WHAT BENEFITS ARE AVAILABLE?

The Workers' Compensation Law provides two basic benefits to the injured worker:

Medical Benefits. An injured worker is entitled to whatever reasonable and necessary medical services are required to treat the injury and achieve maximum cure. These include but are not limited to doctor and hospital services, nursing services, medication, physical therapy, crutches and any other apparatus or medical service which is necessary. Mileage expense reimbursement for trips to the doctor is also included; consult the Commission's internet site at *www.mwcc.state.ms.us* for current rates. Certain rehabilitation services may also be provided to assist the worker in his recovery and return to gainful employment.

- *Wage Loss Benefits.* If an injured worker is required because of the injury to miss time from work, then he or she is entitled to a wage loss benefit equal to as much as two-thirds of the workers' average weekly wage, subject a maximum weekly amount and to certain time limits which are set by the Legislature. While the worker is under the continuing care of a doctor and is unable to work or to earn full pay, this benefit is known as a "temporary disability" payment. Once the doctor finds the worker has achieved maximum cure or improvement, additional wage loss benefits known as "permanent disability" payments may be due if the worker has a permanent disability or handicap. All wage loss benefits are required to be paid at least every 14 days so long as the covered disability continues, subject to certain statutorily provided time limits.

WHAT IF DEATH OCCURS?

If the injury causes death, the Workers' Compensation Law guarantees the payment of benefits to any surviving spouse and certain surviving dependents. These benefits are payable at least every 14 days, and may continue for up to 450 weeks after the decedent's death. These benefits equal a certain percentage of the deceased worker's average weekly wage, and are subject to a weekly maximum amount set by statute. Also, the employer or its insurance carrier is obligated to pay up to $5,000.00 in funeral expenses, as well as an immediate lump sum payment of $1,000.00 to the surviving spouse.

MORE ABOUT MEDICAL BENEFITS.

The Workers' Compensation Law provides that an injured worker has the right to select one physician or medical provider of his or her own choosing to render treatment. This chosen provider may make one referral of the worker to another specialist to continue treatment without any approval from the employer or its insurance carrier. However, any additional selections or referrals must be approved in advance by the employer or its insurance carrier. The worker is not limited to a licensed medical doctor and may choose, for example, a chiropractor for treatment. The worker is also entitled to mileage reimbursement for trips to the doctor.

IS THERE A DEDUCTIBLE?

There is no deductible to be paid by the worker for any of the benefits received. An employer may have a deductible arrangement with its insurance company, but all workers' compensation benefits are provided at no cost to the employee.

PLEASE BE ADVISED:

"Any employee receiving [medical] treatment or service under the [Workers' Compensation Law] may not be held responsible for any charge for such treatment or service, and no doctor, hospital or other recognized medical provider shall attempt to bill, charge or otherwise collect from the employee any amount greater than or in excess of the amount paid by the employer, if self-insured, or its workers' compensation carrier."

"No agreement by an employee to pay any portion of premium paid by his employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by [the Workers' Compensation Law] shall be valid. Any employer who make a deduction for such purpose from the pay of any employee entitled to [workers' compensation] benefits . . . shall be guilty of a misdemeanor. . ."

HOW ARE PAYMENTS MADE?

All payments are made by the employer or its insurance company, *not* by the Workers' Compensation Commission.

Medical payments should be made directly to the doctor or other medical provider by the employer or its insurance company. Wage loss payments should be made directly to the injured worker or the workers' legal representative. Once started, wage loss or disability payments to the worker should be made at least every 14 days until concluded.

ARE BENEFITS PAID FOR ALL DAYS MISSED FROM WORK?

Medical benefits are paid regardless of the number of days missed from work. If the injured worker suffers fewer than 14 days of disability (days on which the worker is unable due to injury to earn his regular wage) as the result of a job related injury, wage loss payments are not made for the first 5 days. Payment will be made only for the number of days of disability in excess of 5. This is known as the 5 day waiting period. If the worker suffers 14 or more days of disability, then wage loss payments are made for the total period of disability, including the first 5 days.

HOW MUCH ARE WAGE LOSS PAYMENTS?

Depending on the nature of the injury and disability, payments will be as much as two-thirds of the workers' average weekly wage, subject to a maximum weekly amount set by the Legislature. No worker is entitled to receive more than 450 times the maximum weekly amount established by the Legislature, regardless of the type of injury. In death cases, this limit applies to the total of payments to spouse and dependents.

Effective for injuries or fatalities occurring on or after January 1, 2013, the maximum weekly benefit for disability or death is $449.12. The maximum overall limit is 450 times this amount, or $202,104.00. These figures represent the maximum amount which can be paid for an injury or death. Depending on one's average weekly wage, benefits may be less, since you are entitled to the lesser of 2/3 of your average weekly wage or the weekly maximum in effect at the time of your injury. Please consult the minimum/maximum benefits chart available at *www.mwcc.state.ms.us* for the maximum benefit rate for years other than 2013.

HOW LONG WILL WAGE LOSS PAYMENTS CONTINUE?

For a worker permanently and totally disabled, payments will be made for a maximum period of 450 weeks. For injuries which result in less than permanent and total disability, the time limit for payments varies according to the nature of the injury and disability. In cases of death, payments to dependents may not exceed 450 weeks.

WHAT IF THERE IS A PROBLEM?

If you encounter a problem with the way your claim is being handled, or you think you have not received all benefits due, first contact the employer or insurance company representative handling your claim. Many problems can be cleared up with a phone call. Remember, if your claim is accepted and paid, it will be paid by the employer or its insurance carrier and not by the Workers' Compensation Commission. If the problem cannot be resolved in this manner, you may contact the Mississippi Workers' Compensation Commission at 601-987-4200 and ask to speak with a Claims Representative. A Claims Representative may be able to help you resolve your problem.

DOES THE INJURED WORKER NEED AN ATTORNEY?

Fortunately, the majority of claims are handled routinely and without any dispute. However, there are instances when you may not be able to resolve disputes yourself or through a Claims Representative of the Commission. In such cases, the assistance of an attorney can be invaluable. You are not required to hire an attorney, but you may consult with and hire an attorney of your own choosing at anytime. Most attorneys are paid by retaining a percentage of the compensation you receive after the attorney is hired. So long as your claim is pending before the Commission, an attorney may not retain more than 25% of the total compensation paid to you. If your claim is appealed to a court of law, up to 33 1/3% of the total compensation may be set aside for attorney's fees.

SAFETY IS IMPORTANT!

While the Workers' Compensation Law exists to guarantee certain benefits for persons who sustain bona fide work related injuries or illnesses, these benefits are limited and often will not make the injured person whole again. Prevention is the most valuable benefit and every worker should strive to prevent an injury from occurring. By adhering to safe work practices, many injuries can be prevented.

Frequently Asked Questions re: Claims

What is the "waiting period"?

Each state regulates the number of days an injured worker must be off work due to a work related injury before compensation (wage) payments may begin. This period is referred to as a "waiting period" and the number of days varies by state law. The State of Mississippi defines the waiting period as 5 days. Compensation payments begin on the 6th day.

Will an injured worker be paid for the days within the waiting period?

An injured worker may receive compensation payments for the number of days off comprising the waiting period, if he or she is out of work due to the injury longer than a specified period of time.

The reimbursement of waiting period for the State of Mississippi is defined as 14 days following the date of disability according to state law. If an injured worker's disability lasts longer than 14 days, he/she will be reimbursed for the 5 day waiting period.

How do we obtain a list of medical providers or the Employers' Posted Panel?

Rules and regulations regarding approved medical providers and/or Employers' Posted Panels for treatment of injured workers vary by state. It is important for every employer to understand how to identify and utilize medical providers and/or Employers' Posted Panels. For assistance obtaining a list of preferred providers and/or help setting up an Employers' Posted Panel, please contact the claims office at (800) 388-6268.

Do we have to provide light duty?

Providing light duty within the guidelines of a medically restricted employee of a compensable claim often shortens the length and reduces the total cost of the claim. While light duty may not be possible for some employers, it is recommended that all employers work to incorporate a light duty/return to work program.

How is the compensation rate calculated?

The compensation rate is 2/3 of the average weekly gross earnings of the injured worker. The number of weeks used for calculating varies by state and is subject to the state's minimum/maximum at the time of accident. The State of Mississippi uses gross wages for 52 weeks preceding the date of accident to determine the average weekly gross earnings.

How does the claimant obtain their medication?

The injured worker can obtain their medication from any pharmacy. They should provide the pharmacy with the contact information for ACA for further billing instructions and/or approval as provided below:

Associated Claims Administrators, Inc.	Toll Free:	(800) 388-6268
P.O. Box 230848	Fax (Toll Free):	(800) 988-4722
Montgomery AL 36123-0848	Email:	claims@acaworkcomp.com

Can an employer be reimbursed for medical billing they pay?

If the authorized medical billing relates to the compensable claim, the billing will be reviewed for possible reimbursement at the state fee schedule rate.

If we have a deductible can we pay the claims up to the deductible amount?

No. A deductible applies per claim and is set up on a reimbursement basis. That means you, the employer, should file a First Report of Injury on all work related accidents. If our investigation leads to payment of the claim, we will cover costs first dollar and submit one or more invoices to you for reimbursement as payments are made up to the total/maximum per claim deductible amount noted on your policy.

Not all policies have a deductible. Your policy will include a deductible amount on the Workers' Compensation Policy Information Page if your policy has a deductible.

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 #

SIC CODE | EMPLOYER FEIN | PHONE #

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

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

 # DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did **not** occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

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 - Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.

ASSOCIATED CLAIMS ADMINISTRATORS
P.O. Box 230848
Montgomery, AL 36123-0848
334-271-6767 (main)
1-800-388-6268 (toll free)
1-800-988-4722 (fax)

WAGE STATEMENT

CLAIMANT: _____ DATE OF INJURY: _____

A. The following table shows the wages earned by _____ employed as a _____ during the period stated.

	MONTH	DAY	YEAR	GROSS WAGES		MONTH	DAY	YEAR	GROSS WAGES		MONTH	DAY	YEAR	GROSS WAGES
1					19					37				
2					20					38				
3					21					39				
4					22					40				
5					23					41				
6					24					42				
7					25					43				
8					26					44				
9					27					45				
10					28					46				
11					29					47				
12					30					48				
13					31					49				
14					32					50				
15					33					51				
16					34					52				
17					35					TOTAL				
18					36					GRAND TOTAL				

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT STATEMENT.

_____, TITLE _____

DATE: _____

Associated Claims Administrators

RE: WAGE STATEMENT

Employee:	
Employer:	
Date of Injury:	
File Number:	

Dear Insured:

In order to calculate this employee's Workers' Compensation Benefits, we must have the gross weekly wages for the 52 weeks immediately preceding this accident. Include the value of any fringe benefits that will not be paid in behalf of the claimant during the disability period.

Please complete the form and return it to this office as soon as possible. If this employee has not been in your employment for longer than two months, submit the wages of a similar employee doing the same type of work over a one-year period of time.

Your immediate response will help speed the processing of this claim. If you have any questions, please contact us at the number above.

Sincerely,

Associated Claims Administrators

NOTICE TO THE MISSISSIPPI WORKER'S COMPENSATION COMMISSION OF

PHYSICIAN OF CHOICE

Employee's Name: _____

Employer's Name: _____

Date of Alleged Injury: _____

Claim Number: _____

I am claiming to have sustained an injury involving my _____

I am _____ am not _____ claiming that my medical condition is work related.

I understand that under the MS Worker's Compensation Law I have the right to choose one (1) physician to render treatment to me.

I also understand that any referral to any other physician must be made by my one (1) chosen physician.

I also understand that my employer (or Worker's Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

_____ I accept as my choice of physician my employer's tender of treatment by

Dr. _____

_____ I elect to choose my own physician to render treatment, and that choice is

Dr. _____

_____
Employee's Name Printed

_____
Employee's Signature

_____
Date

Witnessed by:

_____

_____

<u>This Form Should Be Completed By Injured Employee Only</u>

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.