Workers' Compensation Insurance

Instructions and forms for reporting any injury or accident

In the event an employee injury at work you should do the following:

A. Provide first aid treatment.

B. If emergency treatment is necessary provide transportation to an Emergency Room facility.

C. If non-emergency treatment at a medical facility or physician's office is needed or requested, you may recommend a physician to the employee but the injured worker has the right to select his/her own treating physician. It is highly recommended that all employees are drug tested at the time of the first visit to a medical facility or physician. In many states these drug tests are required by law.

D. Complete the First Report of Injury packet. The packet is attached and may be copied. It is best if you keep one on hand at all times. It is required that completion of the First Report of Injury packet be completed within 24 hours of the accident. If the accident is serious, please notify us by telephone immediately at 601-981-3663. Rapid response on your part will hold down on charges against your account. It is best to send a copy of these forms with the injured employee to the medical provider so that the provider knows exactly how to proceed.

E. Fax a copy of the First Report of Injury to us at 601-987-3027. Most carriers require that we forward them a copy from you within 24 hours. You should state in the report if there is any expectation that the injured employee missing any time at work and, if so, some estimate of how much time will be lost.

Once a claim has been reported all medical bills, medical reports and other correspondence will be handled by the carrier. We are always here to help in any way we can so feel free to give us a call.

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

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.

AFFIDAVIT OF VERIFICATION OF INJURY

Under the Workers' Compensation Laws of the State, all injuries occurring on the job must be reported to the employer immediately, in truth and with a statement consisting of full detail about the injury.

You have reported to your employer that you received an injury while on the job. Please fill out the following report under sworn testimony that all information you are about to give is true. If any of the information is found false, you are subject to fines and possible imprisonment.

NAME:_____

ADDRESS: _____

CITY, STATE, ZIP:_____

PHONE:_____

DATE OF INJURY:_____
DATE TREATED BY MEDICAL PROFESSIONAL:_____
DATE OF RELEASE:_____

NATURE OF INJURY:_____
_____
_____
_____

CAUSE OF INJURY:_____
_____
_____
_____

DESCRIPTION OF INJURY:_____
_____
_____
_____

I swear that the information that I have filled out is true and that I understand the penalties should my employer find the statements false.

_____ _____

Employee Signature Date Witness Signature Date

AFFIDAVIT OF VERIFICATION OF WITNESS TO INJURY

Under the Workers' Compensation Laws of the State of Mississippi, all injuries occurring on the job must be reported to the employer immediately, in truth and with a statement consisting of full detail about the injury.

You were a witness to an accident at your job. Please fill out the following report under sworn testimony that all information you are about to give is true. If any of the information is found false, you are subject to fines and possible prison time.

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE:_____

DATE OF INJURY:_____

CAUSE OF INJURY:_____
_____
_____

DESCRIPTION OF WHAT YOU SAW:_____
_____
_____

COULD THIS ACCIDENT HAVE BEEN AVOIDED?_____
_____
_____

I swear that the information that I have filled out is true and that I understand the penalties should my employer find the statements not true.

_____

Employee Witness Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, hereby authorize any doctor, physician, psychologist, hospital, or other provider of medical and related care to release unto my employer and their workers compensation administrator, their agents, employees, or attorneys, copies of all medical reports, psychological test results, opinions, records, x-rays, x-ray reports, laboratory reports, nurses notes, physicians orders and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as the claim against my above named employer and carrier is pending.

_____

Injured Employee Signature Date

NOTICE TO
WORKERS' COMPENSATION PROVIDER OF PHYSICIAN CHOICE

Claimant's Name_____

Employer's Name: _____

Injury Date_____

I understand that under State Workers' Compensation Law I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

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

I also understand that my employer (or workers' 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 recommended for treatment.

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

Claimant's Name:_____

Signature:_____Date_____

Witnessed by:_____