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:**]**

Normandy Insurance Company

(Name of insurance carrier or self-insurance group)

4800 N. Federal Highway, Suite 302A, Boca Raton, FL 33431

Report a claim (833) 968-7642

(address & telephone number)

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

Normandy Insurance Company

(Name of third party claims administrator or claims office)

4800 N. Federal Highway, Suite 302A, Boca Raton, FL 33431

Report a claim (833) 968-7642

(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:**]**

Normandy Insurance Company

(Nombre del asegurador o grupo de seguro propio)

4800 N. Federal Highway, Suite 302A, Boca Raton, FL 33431

Report a claim (833) 968-7642

(dirección y número de teléfono)

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

Normandy Insurance Company

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

4800 N. Federal Highway, Suite 302A, Boca Raton, FL 33431

Report a claim (833) 968-7642

(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

SIC CODE

EMPLOYER FEIN

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

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 ☐ MONTH ☐ WEEK ☐ 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

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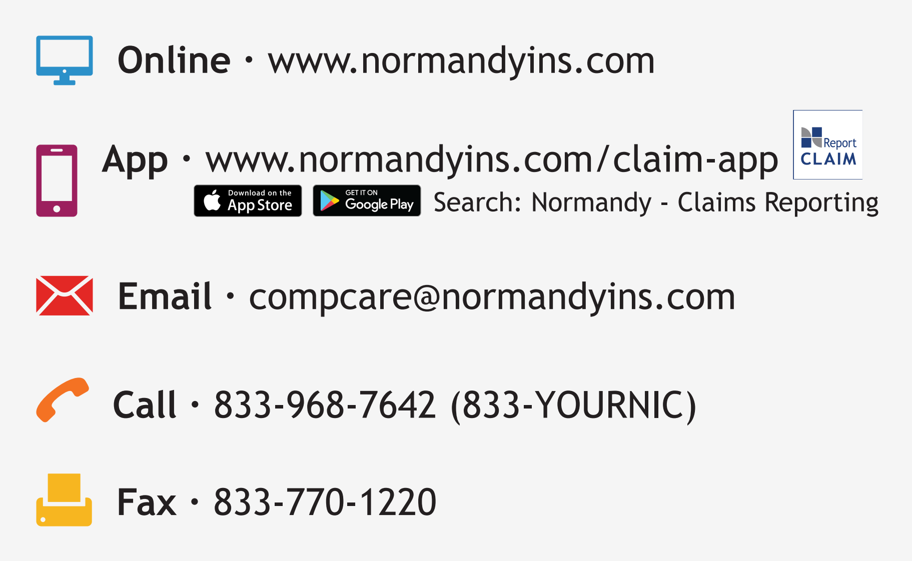
No matter how large or how small,
You must remember to report them all.

Report ALL work-related incidents IMMEDIATELY to your supervisor.

Report every injury that occurs, even if you don't need medical attention.

Any unsafe work conditions should also be reported to your supervisor so that they may be corrected.

How to report a work-related injury



You do not need to wait until the incident report form is completed. Simply report the injury to Normandy Insurance right away with whatever information you have.

Questions?
Call 866-688-6442
Visit us at www.normandyins.com

REPORTING A CLAIM

- Once an employee reports an injury, provide the employee instructions on how to obtain medical care
  - **In an emergency, dial 911** or get the employee to the closest hospital, emergency room or medical facility In a non-emergency situation, the employee should be directed to an urgent care or walk-in clinic you have selected
  - Contact the medical provider/facility to let them know that an employee is being sent over for treatment and that a drug test should be completed on the injured employee

- To report a claim, **notify Normandy Insurance IMMEDIATELY (within 24 hours) via:**
  - Phone at **833-968-7642** **(833-YOURNIC)** (this is the preferred method of reporting a claim), or
  - Email the completed First Notice of Injury form (DWC-1) to compcare@normandyins.com, or
  - Online at www.normandyins.com, or
  - Fax the completed First Notice of Injury form (DWC-1) to 833-770-1220
  - Immediate notification of a claim may help reduce the cost of the claim
  - Your company could be fined by the state for failure to report a claim to your insurance carrier

- If there is a job-related death or hospitalization of 1 or more employees you must notify OSHA **within 8 hours**, and each work-related inpatient hospitalization, as well as amputations and losses of an eye must be reported to OSHA **within 24 hours**. The reporting regulations affect all employers covered by OSHA, even those who are partially exempt from maintaining injury and illness records
  - The Occupational Safety and Health Administration (OSHA) in your state by telephone to the OSHA toll-free central telephone number, 1-800-321-OSHA (1-800-321-6742). Or by electronic submission using the reporting application located on OSHA's public Web site at www.osha.gov.

- Have the injured employee and supervisor and/or witnesses complete an Accident Investigation Report form
  - **NOTE**: **If you do not agree with the description of the accident or believe that an accident did not occur, you are still required to report the incident to Normandy. It is imperative that a claim be reported, even if it is questionable.**

- Maintain continuous contact with the injured employee to let them know that you are concerned about their well-being and that work is available. If an employee is released by their treating physician to return to work in an alternate duty capacity, you should attempt to make the necessary accommodations to bring the injured employee back into the workplace

- You can expect to hear from your adjuster within 24 hours of reporting a claim and also throughout the duration of the claim, but it is important that you also keep in touch with your adjuster.

- Provide your adjuster with any pertinent information that you may have with regard to your claims

- If an employee needs further medical treatment for the same injury or is having problems with claims payments, instruct them to contact their adjuster at 866-688-6442.

- Please visit www.normandyins.com for more information.

Claim Reporting Instructions

To Report A Claim:

Phone: **833-968-7642 (833-YOURNIC)**

Online: **www.normandyins.com**

Email: **compcare@normandyins.com**

Fax: **833-770-1220**

PHONE REPORTING:

If reporting by ***PHONE***, the operator that answers the phone will ask question in regards to the accident. S/he will also obtain some personal information about the injured worker that is required in order to file a workers' compensation claim.

If necessary that operator will either connect the caller with the adjuster in order to obtain physician information in regards to where to treat. If the call is placed after hours that operator will provide the physician information.

FAX OR EMAIL REPORTING:

If reporting by ***FAX*** or ***EMAIL***, claims should be reported on the **State Form DWC-1, First Report of Injury or Illness.** The following information is required for claim entry:

- Full name, address, telephone number of injured employee
- Occupation, date of birth, sex of injured employee
- The injured employee's Social Security number
- Date and time of accident
- Employee's description of accident
- Injury/illness that occurred, part of body injured
- Company name, phone, address; and policy number, if known
- Employer's location address is different from above
- Did the employee return to work? If so, note the date.
- Do you (the employer) agree with the accident?
- Name of physician or hospital where employee was sent by you for treatment
- Place/address accident occurred*
- Employee date of hire*

**Not required, but preferred*

A PDF version of the DWC-1 form that can be completed electronically is available for your convenience if you choose to report a claim via email or fax. Please contact your adjuster at **866-688-6442** to get a copy of this form.

First Fill Form

Client Name: Normandy Insurance

1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for up to **7** Days, and please fill out the information below:

Injured Worker Name:	**SS#:**	
Injured Worker DOB:	**Injured Worker Phone:**	
Injured Worker Employer:	**Date of Injury:**	
Injured Worker Address:		
City:	**State:**	**Zip:**

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
- **Usted, el trabajador lesionado, deberá llevar este formulario y entregarlo en la farmacia junto con sus recetas relacionadas con el tratamiento de su lesión/enfermedad laboral.**

3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **S1 Medical** using the following information:

BIN	PCN	Group Id	Member Id
610237	123119	NOR001	Injured Worker SS#

- Prescription(s) will fill for up to **7 Days.** If there is a remaining balance on the script after it is filled, S1 Medical will call back if and when the balance has been approved. If you need assistance, please call **S1 Medical** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332

COMO REPORTAR UNA RECLAMACIÓN

- Una vez que un empleado reporta una lesión o una enfermedad, dele instrucciones sobre cómo obtener atención médica.
  - **En caso de emergencia, marque el 911** o lleve al empleado al hospital, sala de emergencias o centro médico más cercano
    En una situación que no sea de emergencia, el empleado debe ser dirigido a una clínica de atención urgente (urgente care) o ambulatoria (walk-in) que usted haya seleccionado.
  - Contacte al proveedor/centro médico para informarles que se va a enviar a un empleado para que reciba tratamiento y que se debe realizar una prueba de drogas al empleado lesionado

- Para informar de un accidente, **notifique a Normandy Insurance INMEDIATAMENTE (en un plazo de 24 horas) a través de:**
  - Por teléfono, llamando **al 833-968-7462** **(833-YOURNIC)** (este es el método preferido para notificar un accidente), o
  - Envíe por correo electrónico el Formulario de Primera Notificación de Lesión diligenciado a **compcare@normandyins.com** , o
  - En línea en **www.normandyins.com,**o
  - Envíe por fax el Formulario de Primera Notificación de Lesión (DWC-1) diligenciado al 833-770-1220
  - La notificación inmediata de un accidente puede ayudar a reducir el costo del mismo
  - Su empresa podría ser multada por el Estado por no comunicar un accidente a su aseguradora

- Si se produce una muerte u hospitalización relacionada con el trabajo de uno o más empleados, debe notificar a la OHSA **en un plazo de 8 horas**, y cada hospitalización relacionada con el trabajo, así como las amputaciones y pérdidas de un ojo deben notificarse a la OSHA **en un plazo de 24 horas**. La normativa de notificación afecta a todos los empleadores cubiertos por la OSHA, incluso a los que están parcialmente exentos de mantener registros de lesiones y enfermedades
  - La Administración de Seguridad y Salud Ocupacional (OSHA) de su estado llamando al número de teléfono central gratuito de la OSHA, 1-800-321-OSHA (1-800-321-6742). O bien mediante el envío electrónico a través de la aplicación de notificación que se encuentra en el sitio web público de la OSHA en **www.osha.gov.**

- Hacer que el empleado lesionado y el supervisor y/o los testigos completen un formulario de Informe de Investigación de Accidentes
  - **NOTA**: **Si no está de acuerdo con la descripción del accidente o cree que no se ha producido un accidente, usted sigue estando obligado a informar del incidente a Normandy. Es imperativo que se reporte un accidente, aunque éste sea dudoso.**

- Mantenga un contacto continuo con el empleado lesionado para hacerle saber que se preocupa por su bienestar y que el trabajo está disponible. Si el médico tratante autoriza a un empleado a volver al trabajo en una capacidad de trabajo alternativo, usted debe intentar hacer los ajustes necesarios para que el empleado lesionado vuelva a su lugar de trabajo.

- Usted puede esperar tener noticias de parte de su ajustador dentro de las 24 horas de haber reportado un accidente y también durante la duración de la reclamación, pero es importante que usted también se mantenga en contacto con su ajustador.

- Proporcione a su ajustador cualquier información pertinente que pueda tener con respecto a sus reclamaciones

- Si un empleado necesita más tratamiento médico por la misma lesión o tiene problemas con los pagos de las reclamaciones, indíquele que se ponga en contacto con su ajustador en el 866-688-6442.
- Para más información, por favor visite **www.normandyins.com** .

Instrucciones para reporte de reclamaciones

Para Reportar un Accidente:

Teléfono: 833-968-7462 (833-YOURNIC)

En línea: www.normandyins.com

Email: compcare@normandyins.com

Fax: 833-770-1220

REPORTAR POR VÍA TELEFÓNICA:

Si se reporta por vía ***TELEFÓNICA***, la operadora que contesta el teléfono hará preguntas en relación con el accidente. También obtendrá algunos datos personales del trabajador lesionado que son necesarios para presentar una reclamación de indemnización por accidente de trabajo.

Si es necesario, ese operador pondrá en contacto a la persona que llama con el ajustador para obtener información respecto del médico y lugar de tratamiento. Si la llamada se realiza fuera del horario de atención al público, el operador proporcionará la información del médico.

REPORTE POR FAX O CORREO ELECTRÓNICO:

Si se reporta por ***FAX*** o ***EMAIL***, los accidentes deben notificarse en el **formulario estatal DWC-1, First Report of Injury or Illness** form**.** La siguiente información es necesaria para presentar la reclamación:

- Nombre completo, dirección y número de teléfono del trabajador lesionado
- Ocupación, fecha de nacimiento, sexo del empleado lesionado
- Número de Seguridad Social del trabajador lesionado
- Fecha y hora del accidente
- Descripción del accidente por parte del empleado
- Lesión/enfermedad ocurrida, parte del cuerpo lesionada
- Nombre de la empresa, teléfono, dirección y número de póliza, si se conoce
- La dirección del empleador es diferente a la anterior
- ¿El empleado volvió a trabajar? Si es así, anote la fecha.
- ¿Está usted (el empleador) de acuerdo con el accidente?
- Nombre del médico u hospital al que fue enviado el empleado para su tratamiento
- Lugar/dirección donde ocurrió el accidente*
- Fecha de contratación del empleado*

**No es necesario, pero sí preferible*

Para su comodidad, existe una versión en PDF del formulario DWC-1 que puede diligenciar electrónicamente si decide reportar un accidente por correo electrónico o fax. Por favor, póngase en contacto con su ajustador en **el 866-688-6442** para obtener una copia de este formulario.

First Fill Form

Client Name: Normandy Insurance

1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for up to **7** Days, and please fill out the information below:

Injured Worker Name: | **SS#:**
Injured Worker DOB: | **Injured Worker Phone:**
Injured Worker Employer: | **Date of Injury:**
Injured Worker Address:
City: | **State:** | **Zip:**

2. Instructions for the **INJURED WORKER** / Instrucciones para el **TRABAJADOR LESIONADO**:

- **You, the injured worker, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**
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