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 maintains workers' compensation insurance coverage with the following:

LUBA CASUALTY INSURANCE COMPANY
P.O. BOX 98082
BATON ROUGE, LA 70898-9082
1-888-884-5822 / 225-389-5822

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

LUBA CASUALTY INSURANCE COMPANY
P.O. BOX 98082
BATON ROUGE, LA 70898-9082
1-888-884-5822 / 225-389-5822

III. This workers' compensation coverage is effective for the following period:

January 1, 2018 to **January 1, 2019**.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

Rhonda P. Clark, PhD
(Name of employer contact person)

Risk Manager, Diocese of Biloxi
(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.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Catholic Diocese of Biloxi
1790 Popps Ferry Road
Biloxi, MS 39532

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION: MS

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE: 7997

EMPLOYER FEIN: 640598427

CARRIER/CLAIMS ADMINISTRATOR

LUBA
PO Box 98082
Baton Rouge, LA 70898-9082
1-888-884-5822

POLICY PERIOD: 1/1/2018 to 1/1/2019

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
LUBA
PO Box 98082
Baton Rouge, LA 70898-9082
1-888-884-5822

CARRIER FEIN: 20-3947910

POLICY/SELF-INSURED NUMBER: 028000018593118

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.

LUBA WORKERS' COMP
REPORTING CLAIMS - MISSISSIPPI

PROMPT AND ACCURATE BENEFITS ARE OWED TO AN INJURED EMPLOYEE ONCE THEIR CLAIM IS DETERMINED TO BE COVERED UNDER WORKERS' COMPENSATION. YOU MUST REPORT ALL WORK-RELATED ACCIDENTS IMMEDIATELY TO ENSURE PROPER DELIVERY OF BENEFITS. DELAY IN THESE BENEFITS MAY EXPOSE BOTH YOU AND LUBA WORKERS' COMP TO PENALTIES AND ATTORNEY FEES.

When an accident is timely reported, we are able to conduct a prompt investigation into the facts of the accident. Prompt reporting also enables us to control the claim from the beginning, which in turn may lead to cost savings. Once our investigation has been completed, we will pay the claims we owe and defend the claims that are not owed under workers' compensation. **Timely reporting of each and every work-related accident saves you money!**

There are 2 types of workers' compensation claims that can be reported:

1. **Medical Only** – These are claims that do not incur indemnity benefits (wage loss benefits).
2. **Lost Time** – These are claims that incur both medical and indemnity benefits.

There are currently 4 ways you may report a claim to us:

1. **Report of Injury by Telephone** – This is the **most preferred** way to report a new claim.
   Simply call **(888)884-5822 or (225)389-5822** and you will be connected to our intake specialist who will gather all of the claim information from you over the telephone.

   We will enter the information on the form for you and once completed, your new claim will go to the proper claims adjuster. This relieves you of the paperwork associated with the reporting of a new claim. We will complete all necessary forms and handle the filings with the Mississippi Workers' Compensation Commission.

   Some of the information you will need when reporting the claim by phone is:

   a. Employee name, Social Security number, date of birth and any other information regarding your employee
   b. Date and facts of accident
   c. Description of Injury/Illness
   d. Any medical treatment information that may have already taken place
   e. Class code or job description being paid under

2. **Report of Injury by E-Mail** – You may submit a completed First Report of Injury or Illness via e-mail to FROI@lubawc.com.

3. **Report of Injury by Fax** – You may submit a completed First Report of Injury or Illness via fax to **(225)389-9300, Attn: Claims Intake**. Again, we will make the necessary filings with the Mississippi Workers' Compensation Commission.

4. **Report of Injury by Mail** – If phone or fax is unavailable, you may submit a completed First Report of Injury or Illness via mail to:

   LUBA Workers' Comp
   Attn: Claims Intake
   P.O. Box 98082
   Baton Rouge LA 70898-9082

PLEASE REMEMBER THAT PROMPT REPORTING IS THE KEY TO PROPER HANDLING OF YOUR WORKERS' COMPENSATION CLAIM. THANK YOU FOR YOUR COOPERATION!