MISSISSIPPI WORKERS COMPENSATION COMMISSION

ANNUAL ASSESSMENT REPORT
(INSURANCE COMPANY)

The Six (6) digit Carrier No. MUST BE Included when submitting.

In accordance with Code Section 71-3-99, Mississippi Code of 1972, this report is to be submitted to the Commission on or before March 1, 2023, and is to cover compensation and medical payments for the year period from January 1, 2022, through December 31, 2022. IF THIS REPORT IS RECEIVED AFTER March 1st, A LATE REPORTING PENALTY OF TWENTY DOLLARS ($20.00) PER DAY WILL BE ASSESSED.

Carrier No:

Make address corrections in corresponding space provided.
Company name changes **MUST** by official letter to the Executive Director.

COMPENSATION REPORT

The payments below were made in accordance with the Mississippi Workers' Compensation Law:
Total of all payments, to include weekly compensation payments, lump sum payments, compromise settlements, rehabilitation payments, and funeral benefits paid for the one-year period from January 1, 2022 through December 31, 2022.

$ __ __ __ , __ __ __ , __ __ __ . __ __

Total compensation payments reported to State Insurance Department for the one-year period from January 1, 2022 through December 31 2022.

(Amount on page 15, line 16 – Annual Statement)

$ __ __ __ , __ __ __ , __ __ __ . __ __

Explanation of discrepancies: _____

MEDICAL REPORT

The payments below were made in accordance with the Mississippi Worker's Compensation Law:
Total medical payments made for the one-year period from January 1, 2022, through December 31, 2022.

$ __ __ __ , __ __ __ , __ __ __ . __ __

The medical payments reported to State Insurance Department from the one-year period from January 1, 2022, through December 31 2022.

(Amount on page 15, line 16 – Annual Statement)

$ __ __ __ , __ __ __ , __ __ __ . __ __

Explanation of discrepancies: _____

CERTIFICATION

(Insurer must complete and sign Certification. Incomplete forms will be returned.)

I, _____, do hereby certify that the foregoing is true and correct report of payments made by_____, a duly qualified insurer under the Workers' Compensation Law of the State of Mississippi; and that I am an official of said insurer in the capacity of _____, and am thereby qualified to sign this report.

Signed this _____ day of _____,2023. _____

Original Signature (Required)

Mail to: Mississippi Workers' Compensation Commission, Attn: Business Office, P.O. Box 5300, Jackson, MS 39296-5300
OR Overnight to: Mississippi Workers' Compensation Commission, Attn: Business Office, 1428 Lakeland Drive, Jackson, MS 39216

MISSISSIPPI WORKERS COMPENSATION COMMISSION

ANNUAL ASSESSMENT REPORT

(SELF-INSURER)

The Six (6) digit Carrier No. MUST BE Included when submitting.

In accordance with Code Section 71-3-99, Mississippi Code of 1972, this report is to be submitted to the Commission on or before March 1, 2023, and is to cover compensation and medical payments for the year period from January 1, 2022, through December 31, 2022. IF THIS REPORT IS RECEIVED AFTER MARCH 1st, A LATE REPORTING PENALTY OF TWENTY DOLLARS ($20.00) PER DAY WILL BE ASSESSED.

Carrier No:

Make address corrections in corresponding space provided.
Company name changes **MUST** by official letter to the Executive Director.

COMPENSATION REPORT

The payments below were made in accordance with the Mississippi Workers' Compensation Law:
Total of all payments, to include weekly compensation payments, lump sum payments, compromise settlements, rehabilitation payments, and funeral benefits paid for the one-year period from January 1, 2022 through December 31, 2022.

$ __ __ __ , __ __ __ , __ __ __ . __ __

MEDICAL REPORT

The payments below were made in accordance with the Mississippi Worker's Compensation Law: Total medical payments made for the one-year period from January 1, 2022, through December 31, 2022.

$ __ __ __ , __ __ __ , __ __ __ . __ __

CERTIFICATION

(Self-Insurer must complete and sign Certification. Incomplete forms will be returned.)

I, _____, do hereby certify that the foregoing is true and correct report of payments made by_____, a duly qualified insurer under the Workers' Compensation Law of the State of Mississippi; and that I am an official of said insurer in the capacity of _____, and am thereby qualified to sign this report.

Signed this _____ day of _____ 2023. _____

Original Signature (Required)

Mail to: Mississippi Workers' Compensation Commission, Attn: Business Office, P.O. Box 5300, Jackson, MS 39296-5300
OR Overnight to: Mississippi Workers' Compensation Commission, Attn: Business Office, 1428 Lakeland Drive, Jackson, MS 39216