WORKERS' COMPENSATION NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of West Virginia, hereby gives notice to employees that the employer has secured Workers' Compensation insurance coverage for its employees in accordance with the provisions of said law, by insuring with:

PO BOX 15144
Worcester, MA 01653
1-800-628-0250

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

For questions about a claim, contact:

Employer Representative:_____
Business Address: _____
Phone Number: _____

_____
NAME OF EMPLOYER

Dated: _____