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:

AmTrust Insurance Company

(Name of insurance carrier or self-insurance group)

P.O. BOX 94405, CLEVELAND, OHIO 44101

888-239-3909

(address & telephone number)

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

AmTrust Insurance Company

(Name of third party claims administrator or claims office)

P.O. BOX 94405, CLEVELAND, OHIO 44101

888-239-3909

(address & telephone number)

III. This workers' compensation coverage is effective for the following period: July 1 2025 to July 1, 2026.

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

Carrie Bryson

(Name of employer contact person)

Human Resources

(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, o mantiene seguro de compensación al trabajador con el siguiente:

AmTrust Insurance Company

(Nombre del asegurador o grupo de seguro propio)

P.O. BOX 94405, CLEVELAND, OH 44101

888-239-3909

(dirección y número de teléfono)

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

AmTrust Insurance Company

(Nombre del asegurador o grupo de seguro propio)

P.O. BOX 94405, CLEVELAND, OH 44101

888-239-3909

(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:
1 de julio de 2025 hasta 1 de julio de 2026.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

Carrie Bryson

(Nombre de la persona de contacto del empleador)

Human Resources

(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.

Employee Certificate of Receipt & Acknowledgement

I, the undersigned employee, acknowledge that I have received and reviewed the following documents: ▪ Workers' Compensation Notice of Coverage.

I understand that I am responsible for reading and complying with the provisions outlined in these documents as a condition of my employment. By signing below, I confirm that I am aware of the behaviors prohibited by these policies and acknowledge that violations may result in disciplinary action, up to and including termination.

Policy Receipt and Review

I certify that I have read and agree to each of the following Policies by initialing in the space provided:

________________________________ **Workers' Compensation Notice of Coverage**

Certification of Understanding and Compliance

By my signature below, I further confirm:

1. Compliance: I understand my duty to comply with and abide by all policies.
2. Access: I know that copies of these policies are available to me at any time on hireupss.com in the "Employee Resources" section.
3. Clarification: I understand that if I have any questions or concerns about the policies, I can and should seek assistance from a representative of Hire Up before or after signing this document.
4. Copy: I understand that I may request and receive a copy of this signed Certificate of Receipt.

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Signature Date

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Full Name