MISSISSIPPI WORKERS' COMPENSATION COMMISSION

MWCC FILE NO. ____________________________________ Injury Date _____/______/______

Carrier File No. ____________________________________ Disability Date _____/______/______

Type of NOTICE: (Click to select)
___________ **NOTICE OF FIRST PAYMENT OF T.T.D. BENEFITS**
___________ **SUPPLEMENTAL AGREEMENT AS TO COMPENSATION**
___________ **NOTICE OF SUSPENSION OF PAYMENT**

I. GENERAL INFORMATION (Use Tab key to advance through fields)

Employee Name and Address (Include City, State, and Zip)

SSN: _______-______-_______ Birth Date_____/____/_____

Insurance Carrier Name and Address (Include City, State, and Zip)

FEIN: ___________________________

Employer Name and Address (Include City, State, and Zip)

FEIN: ___________________________

Claim Administrator Name and Address (Include City, State, and Zip)

FEIN: ___________________________

II. NOTICE OF FIRST PAYMENT: Please take notice that payment of compensation for temporary total disability has begun and will continue until further notice:

Date of First Check: _____/______/______ Average Weekly Wage: $_____________________

Period Paid From: _____/______/______ to _____/______/______

First Check Amount: $__________________ Compensation Rate: $_____________________

III. SUPPLEMENTAL AGREEMENT: Please take notice that we agree, subject to applicable statutory limitations, to the following:

G **TEMPORARY TOTAL:** Employee again became temporarily totally disabled on _____/______/______, and is now receiving benefits therefor at the rate of $___________________ per week and continuing until further notice.

G **TEMPORARY PARTIAL:** Employee first became, or again became temporarily partially disabled on _____/______/______, and is now receiving benefits therefor at the rate of 2/3 of the decrease in wage earning capacity and continuing until further notice.

G **PERMANENT TOTAL:** Employee is entitled to compensation for permanent total disability commencing on _____/______/______, at the rate of $________________ per week, and continuing for a period of __________ weeks.

G **PERMANENT PARTIAL:** Employee is entitled to compensation for the _________% loss of ___________________________, commencing on _____/______/______, at the rate of $___________________ per week, and continuing for a period of _________ weeks.

G **DEATH:** Dependents are entitled to death benefits commencing on _____/______/______, at the combined rate of $___________________ per week. Said benefits will continue for the statutorily prescribed period. (Itemize below - attach additional page if necessary).

G **OTHER:**____

Death: Name of Beneficiary and Address	Relation	Date of Birth	Weekly Rate
a.			$
b.			$
c.			$
d.			$

IV. NOTICE OF SUSPENSION OF PAYMENT: Please take notice that the payment of compensation has been suspended, and was last paid on _____/______/______, at the rate of $ ________________ per week for the following:

G **TEMPORARY TOTAL** G **TEMPORARY PARTIAL** G **PERMANENT TOTAL** G **PERMANENT PARTIAL** G **DEATH** G**OTHER**_____________________

Reason compensation was suspended: ____.

Average weekly wage at time of injury was $ _____________________. Employee returned to work at weekly wage of $___________________.

I certify that a copy of this Form has been furnished to the above named employee, beneficiary, or representative on _____/______/______.

Name: ____ Title: ___________________________________ Phone:_______________________

Reverse Side to Form B-18

This Form (B-18) combines former MWCC forms B-15, B-16, and B-17.

This Form has been developed by the Commission pursuant to Mississippi Code Annotated Sections 71-3-37(3) and 71-3-85 (3), (6) (1972), as amended, and may be used in lieu of forms B-15, B-16, and B-17. **PRIOR APPROVAL OF THIS OR ANY OTHER FORM USED FOR SUCH PURPOSES IS NOT REQUIRED IN ORDER FOR PAYMENT OF BENEFITS TO BEGIN OR CONTINUE. THE EMPLOYER/CARRIER'S OBLIGATION TO BEGIN OR CONTINUE PAYING BENEFITS IS NOT SUSPENDED PENDING COMMISSION REVIEW OF THIS OR ANY OTHER FORM USED FOR THE SAME PURPOSE. THE COMMISSION WILL NOTIFY THE EMPLOYER/CARRIER IF THERE IS A MISTAKE, DEFICIENCY OR OTHER PROBLEM SO THAT CORRECTIVE ACTION CAN BE TAKEN BY THE EMPLOYER/CARRIER.**

Part I of this Form (General Information) should be completed in full in all cases.

Part II of this Form (Notice of First Payment) should be used when making the first payment for temporary total disability benefits. Mississippi Code Annotated Section 71-3-37 (3) (1972), as amended.

Part III of this Form (Supplemental Agreement) should be used when making the first payment of temporary partial disability benefits, permanent disability benefits (partial or total), death benefits, head or facial disfigurement, maintenance payments in connection with vocational rehabilitation, accelerated permanent disability benefits, and upon the resumption of temporary disability benefits for an additional period. Mississippi Code Annotated Sections 71-3-19, -37(3) (1972), as amended; General Rule 13.

Part IV of this Form (Notice of Suspension) should be used and filed immediately with the Commission upon suspension of payment of compensation benefits. Mississippi Code Annotated Section 71-3-37(3) (1972), as amended.

THE ORIGINAL OF THIS FORM ONLY MUST BE FILED WITH THE COMMISSION, AND A COPY MUST ALSO BE MAILED TO OR FURNISHED TO THE EMPLOYEE, BENEFICIARY, OR REPRESENTATIVE BY THE EMPLOYER/CARRIER.