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Mississippi Workers' Compensation Commission

NOTICE OF FINAL PAYMENT

PRINT OR TYPE

GENERAL INFORMATION

MWCC #	CARRIER FILE #
(2) SOCIAL SECURITY #	(3) DATE OF INJURY OR DEATH
(1) EMPLOYEE NAME AND ADDRESS - (INCLUDE CITY, STATE and ZIP)	(4) DATE DISABILITY BEGAN / (5) DATE MAXIMUM MEDICAL IMPROVEMENT
	(6) DATE RETURNED TO WORK / (7) DATE OF FINAL PAYMENT
(8) EMPLOYER NAME AND ADDRESS - (INCLUDE CITY, STATE and ZIP)	(9) INSURANCE CARRIER NAME & SERVICING CO. (if applicable)

COMPENSATION PAYMENTS

Compensation payments were made as follows:

NOTICE: If salary paid in lieu of compensation, report below the amount of compensation which would have otherwise been due.

(10) Average Weekly Wage: $_____

(11) Rate of Weekly Compensation $_____

A. DISABILITY PAYMENTS		B. DEATH PAYMENTS	
(12) ____ Weeks ____ Days Temporary Total	$	(16) ____ Weeks ____ Days (itemize at 26 below)	$
(13) ____ Weeks ____ Days Temporary Partial	$	(17) Payment to Spouse (Section 71-3-25(a))	$
(14) ____ Weeks ____ Days Permanent Partial	$	(18) Funeral Expenses	$
____% loss to _____		(19) Second Injury Fund	$
(15) ____ Weeks ____ Days Permanent Total	$		
Total Disability Payments	**$**	**Total Death Payments**	**$**

C. SETTLEMENT PAYMENTS		D. OTHER PAYMENTS	
(20) Lump Sum	$	(23) Total Medical Expenses	$
(21) Compromise	$	(24) Rehabilitation Expenses	$
(22) Third Party: (Attach order if not approved by MWCC)		(25) Other (Specify)	$
a. Amt. reimbursed for comp. previously paid *(Subtract reimbursements)*	$ ( )		
b. Amt. credited against future liability	$	**TOTAL PAYMENTS** (A + B + C* + D) **If C is a negative amount, **subtract** from total)*	$
Total Settlement Payments	**$**		

(26) Dependents and Spouse Payments Itemized Below (attach separate page if necessary)

Name and Relationship	Rate	Weeks	Days	Total
a.				$
b.				$
c.				$
d.				$

(27) If full compensation was not paid, explain: (attach separate page if necessary)

NOTICE

NOTICE TO EMPLOYEE OR BENEFICIARY

This is **NOT** a release of the employer's or the insurance carrier's workers' compensation liability. It is a statement of workers' compensation benefits already paid. If no further workers' compensation benefits are provided within one (1) year from the date this form is properly filed with the Commission, the right to any further such benefits may be barred by the applicable statute of limitations and this claim finally closed. Exceptions may apply for incompetents or minors. **If you incur additional loss of time from work, additional medical expense, or other additional expense, due to this injury, you should immediately contact your employer, the insurance carrier, or the Mississippi Workers' Compensation Commission for further guidance.**

PHONE #:

Prepared by: _____ Date ___/___/___

Employee's Signature: _____ Date ___/___/___
(or representative or beneficiary)