Commonwealth of the Northern Mariana Islands
Workers' Compensation Commission

NOTICE TO EMPLOYEES

YOUR EMPLOYER IS REQUIRED BY LAW TO PROVIDE YOU WITH A WORKERS' COMPENSATION COVERAGE FOR ANY INJURY SUSTAINED WHILE ENGAGED IN EMPLOYMENT. TO UNDERSTAND YOUR BENEFITS UNDER THIS PROGRAM, READ THIS NOTICE CAREFULLY. CONTACT THE CNMI WORKERS' COMPENSATION COMMISSION OFFICE NEAREST YOU FOR FURTHER INFORMATION.

YOUR BENEFITS:

You are entitled to claim benefits under this program if you suffer a work related injury. Notify your employer of supervisor immediately, in writing, about any injury, including the date, time, and nature of such injury. You are entitled to medical and hospital expenses. The name of your insurer is indicated below. Give the name of your insurer to the doctor or hospital so that they know where to send their report of injury and claim payment for services. If your employer does not pay you compensation benefit, or if your employer disproves your right compensation, CNMI Workers' Compensation Commission listed below for your area.

USE WORKERS' COMPENSATION COVERAGE EVEN IF YOU ARE ENROLLED IN A PREPAID HEALTH INSURANCE PLAN.

You are entitled to all required medical, surgical and hospital services and supplies, including drugs, weekly benefits beginning on the fourth day following the date of injury, if such injury results in your disability. Your weekly disability benefits is 66 2/3% of your average weekly wages, but not more than $140.00 per week. If death results from the injury, your survivors may be entitled to funeral expenses not exceed $1,200.00. Your survivors may also be entitled to weekly benefits.

Premiums for coverage under the Workers' Compensation Program are solely the responsibility of your employer. You do not pay for premium cost.

APPEAL RIGHTS

If you disagree with any decision on your claim for compensation benefits under the CNMI Workers' Compensation Program, you may file an appeal in writing, with the Workers' Compensation Commission.

EMPLOYER CERTIFICATION

In compliance with the CNMI Workers' Compensation Law (Public Law 6-33), the undersigned certifies that he has secured the payment of compensation to his employees.

Name of Carrier: _____	Employer: _____
Address: _____	
Telephone No.: _____	Authorized Signature: _____
Effective Date of Coverage: _____	Title: _____
Expiration of Coverage- _____	Date: _____

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P.O. BOX 5795 CHRB.
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Fax: (670) 532-9510

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San Jose Village
Tinian MP 96952
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Fax: (670) 433-0854

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OF BUSINESS.