



Employer MPN: Distribution & Acknowledgement Form New Policy Only

Company Name: _____

Policy Number: _____

On _____, we have posted the red **“If a Work Injury Occurs”** postings notices in an area
 (Date)
 accessible to all of our employees. We have also posted the **‘Medical Provider Network (MPN)’** posters next to the red **“If a Work Injury Occurs...”** poster. All new employees will be provided with the ‘Time of Hire’ pamphlet as part of their new hire packet.

 (Signature of Company Representative)

 (Date)

 (Signature of Company Witness)

 (Date)

This MPN is administered by CompWest Insurance Company, a division of AF Group, and its subsidiaries. All policies are underwritten by a licensed insurer subsidiary of AF Group.

Mail To:
 CompWest Insurance Company
 PO Box 40790
 Lansing, MI 48901 -7990

Fax To:
 866-540-3893

Email to:
 MPN@compwestinsurance.com

Picture of Posting Notices

Please provide a picture of your posting notices with the following information:

Company name: _____

Date picture taken: _____

Who took the picture: _____

Job title: _____

Where the poster is located: _____

