MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCA-100
Schedule 22

CERTIFICATE OF COMPLIANCE

To be completed and submitted by the employer to the WCA Administrator within 30 calendar days of the effective date of the Workers' Compensation Law, or upon receipt of a new EIN from MISSA or start of operations [if new employer], or upon renewal of the insurance coverage, A copy of the insurance policy must be attached herewith.

Part I: EMPLOYER INFORMATION

1. Business name:	2. Name of employer/owner/director:	
3. Mailing address:	4. Email address:	
5. Employer address:	6. Employer contact no:	
7. EIN No:	8. Date EIN was issued:	9. Date operations started:

10. Type of business:
[ ] Government [ ] SOE [ ] Local Gov't [ ] Sole proprietorship [ ] Partnership

[ ] Association [ ] Corporation [ ] Other .....

Part II: INSURANCE COVERAGE

11. Name and address of insurance carrier	12. Status of coverage: [ ] New [ ] Renewal [ ] Change of carrier
13. Total workers currently employed ..... 15. Total workers currently covered ..... 17. Estimated premium	14. Effective date of policy..... 16. Expiration of policy..... **[ ] Copy of insurance policy is attached**

18. Declaration: I hereby declare, under penalty of perjury, that the information in this Certificate of Compliance are true and correct to the best of my knowledge. I also understand that I am responsible to file this Certificate of Compliance within 30 days of the effective date of the Workers' Compensation Law, upon receipt of EIN from MISSA, start of operations, or renewal of this insurance coverage.

..... 19. Name of person completing this report:	..... 20. Signature
..... 21. Position title	..... 22. Date signed