Republic of the Marshall Islands
Jepilpilin Ke Ejukaan

WORKERS COMPENSATION REGULATION 2023

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Workers Compensation Act 2019

WORKERS COMPENSATION REGULATION 2023

Coming into Operation: *November __, 2023*

The Marshall Islands Social Security Board of Directors makes the following Regulations under Section 740 of the Workers Compensation Act 2019.

PART I - PRELIMINARY

1. Short Title.

These Regulations are the Workers Compensation Regulation, 2023.

2. Commencement.

If approved, these Regulations come into operation on upon approval by Cabinet.

3. Purpose.

The purposes of these Regulations are to provide for the procedures and criteria for the effective implementation of the Workers Compensation Act of 2019.

4. Interpretation.

In these regulations, unless the context otherwise requires:
(a) "Administrator" means the Workers Compensation Administrator also referred to as MISSA Administrator;

(b) "Administration" means the Marshall Islands Workers' Compensation Administration and Marshall Islands Social Security Administration (MISSA);
(c) "Board" means the Workers Compensation Board also referred to as MISSA Board;
(d) "DBA" means Defense Base Act;
(e) "EIN" mean MISSA's Employer Identification Number;
(f) "Employee" means worker for the purposes of this Regulation;
(g) "Government employee" has the same meaning as defined under Regulation 2 of the Public Service Commission;
(h) "Annual Gross Income" means the total sales, services or revenue generated by the business during the period without deducting the cost of goods sold or services and operating expenses
(i) "Local insurance carrier" means Moylan's Insurance Underwriters (Marshalls), Inc. Managing General Agent of First Net Insurance Co. and DB Insurance Co. Ltd, and Marshalls Insurance Agency as part of Century Insurance Co., Inc. (CIC), or any other insurance agency that may be authorized to transact insurance business in the RMI;
(j) "MISSA" means Marshall Islands Social Security Administration;
(k) "MURA" means Military Use of Right Agreement;
(l) "Non-residents" means the same as defined in Section 703 of the RMI Workers' Compensation Act 2019;
(m) "Residents" means the same as the definition in Section 703 of the RMI Workers' Compensation Act 2019;
(n) "Self-employed worker" means an individual, regardless of citizenship, who engages in any trade or business, alone or with one or more staff. A self-employed worker is deemed to be both as an employer and worker for himself/herself;
(o) "Small business" means one whose annual gross income is not more than $25,000;
(p) "SOFA" means Status of Forces Agreement;
(q) "USAG-KA" means United States Army Garrison in Kwajalein Atoll;
(r) "WC" means Workers' Compensation;
(s) "WCA" means Workers' Compensation Administration/tor, or the "Administration/tor";
(t) "WCB" means Workers' Compensation Board or the "Board";

(u) "WCL" means RMI Workers' Compensation Act 2019Law;
(v) "WCP" means RMI Workers' Compensation Program ; and
(w)"WCTF" means Workers' Compensation Task Force or "Task Force".

PART II – ADMINISTRATION AND MANAGEMENT

5. Workers Compensation Board ("WCB" or "the Board").

(1) The nine (9)-member Board of Directors of MISSA shall serve as the Workers Compensation Board or WCB.

(2) The WCB shall:

(a) Make rules and regulations necessary to assure timely payment of compensation and reporting by insurers/insurance carriers;

(b) Select technical consultants, medical advisors, officers, and employees, as it deems necessary;

(c) Disburse from appropriate funds such expenditures as it deems necessary based on a duly approved budget;

(d) Receive services from staff and managers of MISSA to the Board as applicable and necessary;

(f) Have the authority to decide on matters related to adjudication of contested decisions by the Administrator and hear appeals by either party relating to a claim for compensation; and

(g) Consider applications for non-government employers to establish their own self-insurance funds and set arrangements for the financial regulation of these funds.

(3) The WCB shall:

(a) have power to investigate;

(b) make studies and investigations with respect to safety provisions, and causes of injuries in employment;

(c) obtain information from actuarial studies, claims and injury data relevant to the Republic to inform insurers on an appropriate insurance premium for the WCP;

(d) at the beginning of each calendar year, the Board shall submit a report to the Nitijela of data for the preceding fiscal yearthat will be made publicly available on the relevant part of the

MISSA website, including: a detailed statement of receipts of and expenditures from the Special Disability Fund; the number of workplace injuries, amount of premiums paid by each local industry, and the quantum of all claims paid by each insurer;

(e) make recommendations to the Nitijela from time to time to prevent injuries and improve the WCP;

(f) In making such studies and investigations:

(i) obtain the cooperation with any agency charged with the duty of enforcing any law securing safety against injury in any employment covered in the WCL, or with any agency engaged in enforcing any laws to assure safety for employees

(ii) permit any such agency to have access to the records of the Board. In carrying out the provisions of this section, the Board or any officer or employee of the Board is authorized to enter at any reasonable time upon the premises, tracks, wharf, dock, or to enter any building, where an employment covered by the WCL is being carried on, and to examine any tool, appliances, or machinery used in such employment.

(4) No member nor any business associate of a member shall appear as attorney in any proceedings under the Worker's Compensation Act, and no member shall act in any such case in which he or she has an interest, or when he or she is employed by any party with an interest or related to any party with an interest by consanguinity (familial connections) or affinity within the third degree as determined by the common law.

6. Workers Compensation Administration ("WCA" or "Administrator")

The Workers' Compensation Administrator or "Administrator" shall be the same as the Administrator of MISSA, and will have the following functions and authority:

(a) Shall maintain and keep open a Workers' Compensation office during reasonable business hours. The WC Office shall be the offices of MISSA in Majuro and Ebeye;

(b) May issue subpoenas, administer oaths and compel the attendance and testimony of witnesses, or for the production of documents and other evidence during hearings related to claims for compensation;

(c) Conduct hearing on claims for compensation, approve, decline or put on hold a claim for compensation; and

(d) As appropriate, provide information to RMI residents employed on Kwajalein or other USAG -KA bases in the Republic, as to their rights for compensation under either the WCL or DBA.

PART III - REQUIREMENTS FOR SECURITY OF COMPENSATION& MEDICAL SERVICES

7. Security of Compensation.

(1) Unless excluded under this Regulation or the Workers Compensation Act, every employer shall secure the payment of compensation by insuring and keeping insured the payment of such compensation with an insurer which is provable by a certificate of authority to transact general casualty insurance in the Republic. Provided however, the Republic Government or any other approved employer may make compensation payments under the provision of the Government Employee's Self-Insurance fund, or a non-Government Employer Self-Insurance Fund.

(2) Employers shall keep posted a compensation notice in a conspicuous place in the place of business, that confirms the security of compensation, the name and address of the insurer or insurance carrier, and the date of the expiration of the policy.

(3) The employer shall file with the Administrator a Certificate of Compliance see **Schedule 19 WCA-100** consistent with its obligations under sections 733 and 738 of the Workers Compensation Act. The employer shall file with the Administrator within 30 days of the effective date of the Act and shall upon request provide evidence of payment has been secured annually.

(4) The Administrator is required to publish on the public facing website, an annual report of the names and owners of businesses who comply with their obligations under sections 733 and 738 of the Workers Compensation Act, by not later than 31March of each year.

(5) In the case of a non-Government employer seeking to become or maintain being Self-Insured, they shall complete an application in the Form of **Schedule 5** and co-operate fully with any investigation conducted into their application or review initiated to determine whether the approval should be revoked. An application by a non-government employer will address:

(a) whether the employer is able to meet its financial liabilities and can manage financial transactions necessary to make timely payments of compensation and reimbursements as required under the Worker's Compensation Act;

(b) does the employer demonstrate they have the necessary resources for the purpose of administering claims under the Workers Compensation Act;

(c) evidence of the employer actively monitoring the incidence and severity of work injuries arising from employment on all of its locations;

(d) the working conditions under which their employees are employed and the health and safety arrangements for those workers; and

(e) a sound understanding of the supports required for the rehabilitation of injured employees to achieve their recovery and return to work, including providing suitable employment to employees who suffer work injuries.

(6) Upon satisfaction of a non-government employer meeting the requirements in (5) above, the Administrator will recommend to the Board to either approve an application to become Self-Insured for a period no greater than 5 years or decline the application.

(a) If the Board declines the application, it will provide reasons and allow the non-government employer to reapply after 12 months of their decision. The employer will then need to show

evidence of insurance cover from an insurance carrier as per the WCL.

(b) If the Board approves the application, the Self-Insured employer will abide by any conditions associated with the approval, including the identified payment to MISSA of a security bond to meet future liabilities for claims arising from the WCL.

(7) For newly opened businesses, the coverage shall take effect on the first day of operations. Furthermore, employees, regardless of work status or citizenship, shall also be covered on their first day of work.

8. Exclusivity of coverage of Employers and Validation.

(1) Pursuant to Section 4(5)of the Workers Compensation Act, where an employer opted not to be covered under the section, the employer shall:

(a) Submit an application with a prescribed form under **Schedule 1** of the Regulation for valid exemption to the Administrator;

(b) The Administrator upon the receipt of the Application shall within 60 calendar days, consider and upon satisfaction of exemption criteria, grant a period for no greater than five years;

(2) Pursuant to section 733 of the Worker Compensation Act as it relates to the opportunity to opt out of insurance coverage for "small business":

(a) the employer shall declare in the application form under **Schedule 1** acknowledgment of their financial responsibility for the compensation and reimbursement of treatment costs for any employee's work-related injuries or illness;

(b) the business shall submit the two latest annual Gross Revenue Taxation returns filed with the Republic Revenue and Taxation Office to support their application for exemption from purchasing insurance;

(c) based on satisfaction of information provided in (a) and (b) above, the Administrator shall determine whether or not the small business qualifies for exemption from purchasing insurance for a defined period, which shall be no greater than 5 years and

(e) the Administrator will keep a record of those businesses approved for exemption from purchasing insurance and cause such list to be provided to the Board and published in the local media.

9. Requirements for insurers and self-insured employers.

(1) Any employer who opts for self-insurance shall file an application with the prescribed form under **Schedule 5** of the regulations for approval by the Administrator.

(2) The Administrator and Board has the jurisdiction over an insurance carrier or self-insured employer for the purposes of the WCP.

(3) An insurance carrier can only offer insurance coverage under the WCL if it holds a current licence approved by the Banking Commissioner under the Banking Act 1987 to operate as a financial services provider in the Republic.

(4) Any finding or decisions of the Administrator or Board shall be binding on the insurance carrier or self-insured employer.

(5) Unless controverted, an insurer shall pay compensation promptly and directly to the person entitled thereto, without an award, unless however excluded under the WCL.

10. Requirement for immediate Medical Services & Supplies

(1) An injured employee shall request medical treatment, services or supplies to his or her employer in a prescribed form under **Schedule 2** of the Regulations.

(2) Upon the request of the injured employee, the employer shall provide to the injured employee a suitable medical practitioner who will prescribe, diagnose and provide the treatment required, and produce such medical report using the prescribed form under **Schedule 3** of the Regulations. Cost of the medical report shall be paid for by the employer (or their insurer).

Where in the opinion of the Administrator there is need for independent examination, the employer (or their insurer) shall bear the cost of the examination.

(3) An Administrator upon the receipt of the Medical Report under **Schedule 3**, shall immediately transmit a copy, to the claimant, employer, the relevant insurer and any authorized representative, upon request.

(4) Where an employee unreasonably refuses to submit to medical or surgical treatment, Administrator may suspend assessing the claim or if approved, suspend payment if the injured employee has not complied with the medical referral. Upon non-compliance, the Administrator shall notify the claimant using the compensation order as the prescribed form under **Schedule 4** of the Regulation and inform the injured employee and their employer of suspension due to noncompliance.

11. Approved Medical Treatment & Services: Required Treatment outside of the Republic

(1) In the event of a life-threatening injury where treatment is not available in the Republic, or indicated by a recognized physician to be in the best interest of the injured employee to be treated outside of the Republic as the nature of the injury or the process of recovery may require pursuant to section 708 of WCL, the employer, in close coordination with their insurance carrier, shall consider and implement all available remedies to medically evacuate the injured employee to the nearest available hospital in another country where recommended treatment is available. An employer who facilitates such treatment shall reserve the right to controvert the claim if new evidence suggests the injury was not compensable under the WCL.

(2) RESERVED

PART IV - PROCEDURES FOR CLAIM& DETERMINATION

12. Notice of Injury or Death.

(1) An injured employee or an eligible person in the case of death, shall give notice within 30 days after the date of such injury or death to the Administrator and to the employer.

(2) The notice shall be in writing in accordance with the prescribed form under **Schedule 2** of the Regulations.

(3) Notice shall be given to the Administration by personal delivery or by first class mail or secure electronic email, addressed to the

Administrator's office; and to the employer and their insurer, by personal delivery or by sending it by first class mail, postage prepaid, or secure electronic email, addressed to the employer at its last known place of business or electronic email to all his or her available webmail based addresses. If the employer is a partnership, such notice may be given to any partner, or if a corporation, such notice shall be given to any agent or officer thereof upon whom legal process may be served or who is in charge of the business in the place where the injury occurred.

13. Filing of Claims.

(1) A claim for compensation shall be filed with the Administrator in accordance with the prescribed form under **Schedule 6** of the Regulations, at any time after the first four days following any injury, or at any time after death subject to Subsection (3) of this Regulation.

(2) The employee shall file with the claim a medical report in **Schedule 3**, in support of his or her claim to the Administrator.

(3) Within 10 days after such claim is filed, the Administrator, in accordance with the prescribed form under **Schedule 7** of the Regulation, shall notify the employer or any other person (other than the claimant), whom the Administrator considers an interested party, that a claim has been filed.

(4) An Employer must file a response to the claim within 30 days of the injury or illness, refer to **Schedule 18.**

(5) An employer may file an objection contesting acceptance to the claim using Form WCP 501 in **Schedule 11** of the Regulations.

(6) The Administrator shall not accept any claim for compensation that is filed more than one year after the injury or death, subject to the provisions of Section 714 of the WCL.

14. Administrators Investigation and Hearing of Claims

(1) The Administrator shall cause such investigations to be made as he or she considers necessary in respect of the claim.

(2) Based on the investigation and application of the claimant, where the Administrator orders a hearing, the Administrator shall give the

claimant and other interested parties at least 10 days' notice (unless otherwise agreed) in accordance with the prescribed form under **Schedule 8** of the Regulation of such hearing, served personally upon the claimant and other interested parties by registered mail or secure electronic email.

(3) At such hearing, the claimant, the employer or a authorized representatives, may present in writing, and give present oral evidence in relation to such claim. The Board shall provide for the preparation of a record of the hearings and other proceedings before the Administrator.

(4) Within 20 days after such hearing is held, the Administrator may deny the claim or make an Award in respect of the claim in accordance with the prescribed form under **Schedule 4 or 9** (if an agreement is reached) of the Regulations.

(5) The Administrator shall file the order prescribed form under **Schedule 4** within the office of Administrator and shall transmit a copy to the claimant and a copy to the employer and their insurer (where known) by delivery to them in person or by registered or secure electronic mail sent to their last known addresses.

(6) If the Administrator makes an order requiring the payment of compensation, then the employer or their insurer is bound to follow the payment process outlined in section 715 of the WCL.

15. Appeal Against Compensation Order [Award]: Notice

(1) Any party in interest to the claim [compensation order] may file a notice of appeal with the Board.

(2) The appeal shall be filed within 15 calendar days of the filing of a compensation Award in the office of the Administrator to the Board.

(3) The payment of the Award shall not be stayed pending final decision from the appeal unless employer applied to the High Court for a Stay of Order within 15 days. The Administrator after not less than three days' notice to the parties in interest, shall allow the stay of such payments, either in whole or in part.

(4) The person who filed a notice of appeal as in Subsection (1) of this Regulation shall at the same time file a written statement of objection

to the Administrator's decision in accordance with Form WCP 500 **Schedule 15** or WC 202 in **Schedule 16**

(5) The parties in interest may file an opposing statement within 5 business days of service upon them of the appellant's statement in accordance with WCP 500 **Schedule 15** or WC 202 in **Schedule 16**.

(6) A party may request the Board upon written statement to present oral argument on appeal or upon the Board's own request to determine the appeal on written statements in support of or in opposition to the Administrator's decision.

(7) Within 30business days of the filing of the notice of appeal, the Board shall issue a written decision supported by written findings of fact and conclusions of law. The decision of the Board shall be a final administrative decision subject to any judicial review.

(8) If the Board makes an order requiring the payment of compensation, then the employer or their insurer is bound to follow the payment process outlined in section 715 of the WCL.

(9) The Board shall make its decision on the majority of the authorized Board of Directors that are sitting. No member of the Board will participate in such an appeal where there is any conflict of interest appertaining to either party appearing before the Board.

PART V - PROCEDURES FOR PAYMENT

16. Duties of Insurers (which includes self-insured employers)

(1) It is the duty of an insurer to make payments on a timely manner as described in the WCL upon any Awards to be made upon order of the Administrator.

(2) The Insurer will complete and file an annual return by 1 October each year, in accordance with Form WC 402 in **Schedule 17** of the total insurance premiums collected from employers (or the number of employees protected in the case of self-insured) in the Republic. Upon examination of the annual return, the Administrator will calculate the percentage the insurer needs to transfer into the Special Disability fund, and within 30 days of receipt of such calculation from the Administrator, the insurer will make the payment in full.

(3) An insurer will maintain the necessary licence and abide by the conditions of such licence, as required by the Republic's Banking Commissioner.

17. Payment of Compensation without an Award unless controverted.

(1) Compensation shall be paid promptly and directly to the person entitled thereto, without an award, except where liability to pay compensation is controverted by the employer.

(2) Upon making of the first payment, or upon suspension of payment for any cause, the employer (or their insurer) shall immediately notify the Administrator in accordance with a prescribed form in **Schedule 10** of the Regulations that payment of disability benefits has begun or has been suspended, as the case may be.

(3) After investigation by the Administrator, the employer or their insurer, shall abide by any decision of the Administrator to order the reinstatement of the payments of disability benefits.

(4) Where the compensation is controverted, the employer shall file a notice within 14 days upon proof of evidence to the contrary, in accordance with the prescribed in Form WCP-501 **Schedule 11** of the Regulations stating that the right to compensation is controverted.

18. Disability Payments.

(1) The Administrator based on the medical report from a medical practitioner or practitioners shall determine the type [level] of injury and the disability payment an injured employee is eligible for, whether permanent total disability, temporary total disability, permanent partial disability, or temporary partial disability.

An assessment must take into account the following principles:

(a) if a worker presents for assessment in relation to injuries which occurred on different dates, the impairments are to be assessed chronologically by date of injury;

(b) impairments from unrelated injuries or causes are to be disregarded in making an assessment;

(c) impairments from the same injury or cause are to be assessed together or combined to determine the degree of impairment of the worker;

(d) impairment resulting from physical injury is to be assessed separately from impairment resulting from psychiatric injury;

(e) in assessing impairment resulting from physical injury or psychiatric injury, no regard is to be had to impairment that results from consequential mental harm;

(f) any portion of an impairment that is due to a previous injury (whether or not a work injury or whether because of a pre-existing condition) that caused the worker to suffer an impairment before the relevant work injury is to be deducted for the purposes of an assessment.

(2) Upon the determination by the Administrator, disability benefits payment shall be paid to the employee pursuant to Section 709 of the Workers Compensation Act.

(3) Disability benefits shall be paid in bi-weekly instalments, except where the Administrator determines that payment in instalments should be made monthly or at some other interval.

(4) For the purpose of these Regulations:

(a) "permanent total disability" means following an assessment of the degree of impairment resulting from an injury:

(i) where there is evidence that the injury has stabilized; and

(ii) must be based on the worker's current impairment as at the date of assessment, including any changes in the signs and symptoms following any medical or surgical treatment undergone by the worker in respect of the injury; and

(iii) must be made by an accredited medical practitioner acceptable to the Administrator

(iv) the worker is deemed be fully and permanently incapacitated for work.

(b) "temporal total disability" means that the injury has not stabilised and the worker is currently (temporarily)totally incapacitated for work

(c) "permanent partial disability" means

(i) where there is evidence that the injury has stabilised; and

(ii) must be based on the worker's current impairment as at the date of assessment, including any changes in the signs and symptoms following any medical or surgical treatment undergone by the worker in respect of the injury; and

(iii) must be made by an accredited medical practitioner acceptable to the Administrator; and

(iv) the worker is deemed to be only partially and permanently incapacitated for work.

(d) "temporary partial disability" means that the injury has not stabilised and the worker is currently (temporarily) only partially incapacitated for work.

19. Payment for Death

(1) Pursuant to Section 710 of the Workers Compensation Act, the Administrator shall determine person or persons who are eligible to compensation for death of an employee.

(2) For the Administrator to determine the beneficiaries and compensation eligibility and the amounts payable, the Administrator may obtain legal and personal documentation using prescribed form under **Schedule 12** of the Regulations to validate relationships and determine proportionality of payment pursuant to Sections 710 and 711 of the Workers Compensation Act.

(3) An eligible claimant may file with the Administrator personal documentation and relevant information in accordance with the prescribed form under **Schedule 12** of the Regulation.

20. Lumpsum Payment: Application

(1) Where the claimant voluntarily elects a lump sum payment, he or she shall file an application to the Administrator in accordance with the prescribed form WC 203 under **Schedule 13** of the Regulation.

(2) The Administrator shall approve a lump sum payment based on the guiding indicators as follows:

(a) Determination by the Boardin the interests of Justice that the liability of the employer for compensation or any part thereof, be discharged by the payment of a lump sum equal to the present value of future compensation payments commuted, computed at four (4) percent true discount compounded annually;
be discharged by the payment of a lump sum equal to the present value of future compensation payments commuted, computed at four (4) percent true discount compounded annually;

(b) Determination by the Board in accordance with American Experience Table or Mortality or such table as the Commission Board may deem appropriate,the probability of death of such injured employee or other person entitled to disability benefits before the expiration of the period during which he or she is entitled to disability benefits shall be determined

(c) Determination by the Board on the probability of the remarriage of the surviving spouse

(d) The capability of the claimant to make a decsion in their best interest, devoid of any co-ercion from others, including family members

(e) Determination by the Board on the probability of the happening of any other contingency affecting the amount or duration of the disability benefits shall be disregarded. “contingency” means circumstance which is possible but cannot be predicted with certainty.

21. Default of Payments.

(1) In case of default by the employer in the payment of due compensation for a period of 30 days after the compensation is due and payable, the claimant shall apply to the Administrator for a supplementary order.

(2) In doing so, claimant shall notify the Administrator in accordance with the prescribed Form WCA 204 in **Schedule 14** of the Regulations of the employer's failure to pay claimant and the required remedy.

PART VI - PROCEDURES BEFORE THE ADMINISTRATOR

22. Record and the proceedings before the Administrator: General

These rules govern the procedure in proceedings before the Workers' Compensation Administrator. They should be construed and administered to secure the just, speedy, and inexpensive determination of every proceeding. To the extent that these rules may be inconsistent with a governing law and regulation, the latter controls.

23. Designation & Powers.

(1) Designation. The MISSA Administrator is designated as the presiding Administrator for all proceedings unless the Administrator otherwise delegates.

(2) Authority. In all proceedings under this part, the Administrator has all powers necessary to conduct fair and impartial proceedings, including those described in the Administrative Procedure Act.

(3) The Administrator shall regulate the course of proceedings in accordance with applicable law and regulation, and in doing so, the Administrator shall:

- (a) Administer oaths and affirmations and examine witnesses;
- (b) Compel the production of documents and appearance of witnesses within a party's control;
- (c) Issue subpoenas authorized by law;
- (d) Rule on offers of proof and receive relevant evidence;
- (e) Dispose of procedural requests and similar matters;

(f) Terminate proceedings through dismissal or remand when not inconsistent with law and subordinate regulation;
(g) Issue decisions and orders; and
(h) Address any related matters in the course proceedings.

PART VII - MISCELLANEOUS

24. Employers Record of Injury/Death: Record Keeping.

(1) Pursuant to Sections 730 of the Workers Compensation Act, employers are required to keep record of any injury, occupational disease or death of his or her workers.

(2) Such record shall contain information such as disease, disability or death in respect of such injury. In order to carry out the duties set out in Section 741 of the Workers Compensation Act, the Board, or any officer or employee of the Board, is authorized to enter and inspect the records held by an employer.

25. Inspection of Work Premises

(1) The Board authorises the Administrator to have the authority to enter any buildings or premises or obtain any records to inspect for the purposes of work related conditions of the employer or as part of Administrators' inspection in relation to a claim before the Administrator.

(2) The Administrator shall provide reasonable notice to the employer before entering a building or premises to inspect for work related conditions or to or seek to obtain any records to ascertain information in relation to a claim before the Administrator.

SCHEDULE 1

Form WCA - 105

APPLICATION FOR EXEMPTION FROM WORKERS' COMPENSATION COVERAGE

Date:

To: _____
Administrator
Marshall Islands Workers' Compensation Administration
P.O. 175, Majuro
Marshall Islands MH 96960

Dear Administrator _____,

Due to the following reason(s) marked X below, I hereby request for exemption of coverage from the Workers' Compensation Program,or the requirement to purchase insurance, to be implemented on October 1, 2023:

[ ] I am a self-employed worker with no employees and I will take full responsibility of the cost of my treatment for any injury or illness suffered during the ordinary course of my work.

[ ] I am the owner of a small business whose operation involves the employment of members of my immediate familyandothers. The business annual gross income is not more than $25,000. In case of injury or work-related illness of myselfor any staff, including immediate family members, listed in the table below, occurs during the ordinary course of my business,**I commit and promise, under oath below, that I will take full and sole responsibility to reimburse the costs associated with their treatment and any lost wages up to $40,000 until their full recovery.**

	Name	Job title	Nationality	Age
1.	_____	_____	_____	____
2.	_____	_____	_____	____
3.	_____	_____	_____	____
4.	_____	_____	_____	____
5.	_____	_____	_____	____

As required, I also attach the two latest annual Gross Revenue Taxation returns filed with the RMI Revenue and Taxation office to support my application for exemption from purchasing insurance for worker's compensation.

[ ]Other. Explain your reasons(s) in detail. You may use a separate sheet if necessary.

You may contact the undersigned for more information or requirement(s).

I hereby certify, under penalty of perjury that all information and answers that I provided are true and correct to the best of my knowledge and belief.

Name:_____ Signature:_____

Registered name of business: _____ Date:_____

NOTE. This document must be notarized.

On this _____ day of _____, 20____, before me a notary public, the undersigned officer,

personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to this document, and acknowledged that he/she executed the same to the best of his/her knowledge and belief.

In witness hereof, I hereunto set my hand and seal.

NOTARY PUBLIC

SCHEDULE 2

REQUEST FOR MEDICAL TREATMENT OR SERVICES

Form WCA - 200

NOTICE OF EMPLOYEE'S INJURY OR ILLNESS/DEATH & REQUEST FOR MEDICAL TREATMENT OR SERVICES

(To be completed by worker or his representative within 30calendar days after date of injury or illness. The original must be given to the Administrator and a copy is provided to the employer and insurance carrier)

1. Name of injured/deceasedworker:	2. Name of employer:
3. Social Security No:	4. EIN No:
5. Worker's address & contact no.	6. Employer address & contact no:
7. Citizenship:	8. With valid Health Card? [ ] Yes [] No Health card expiry date:
9. Date & time of injury or illness/death:	10. Place where injury or incident occurred:
11. Date & time worker stopped working due to injury or illness/death:	12. Name of supervisor at time of injury or illness/death:
13. Worker's occupation:	Was there someone else other than the worker that caused the incident: [ ] Yes [ ] No If yes, who? …….
Describe in detail how the incident occurred. Tell what the injured worker was doing at the time of the incident. State if there was a witness during the incident and get his statement in writing. Use additional sheet(s) if necessary.	
Effect(s) of the injury. (Name part of body affected, i.e. fractured leg, bruised arm, burnt face, etc.)	
Injured/deceased Worker's/representative signature	If worker can't fill-up this form, name and signature of representative who completed this form:
Date of this notice:	

SCHEDULE 3

MEDICAL PRACTITIONERS REPORT

Form WCA - 600

ATTENDING PHYSICIAN'S INITIAL REPORT OF INJURY AND TREATMENT

This report should be completed and submitted to the Administration within 15 calendar days (see item# 17 of the Authorization for Medical Examination & Treatment for address). Copies must also be provided to the employer and Insurance Carrier (see items 2 & 18 of the Authorization for Medical Examination & Treatment for address)

1 Brief history of injury as described by the injured worker or witness	
2 Was there any history or evidence of pre-existing injury, disease or physical impairment? [ ] Yes [ ] No If Yes, please briefly describe.	
3 What are your findings?	4 What is your diagnosis?
5 Do you believe that the condition found was caused or aggravated by the accident described? [ ] Yes [ ] No Please explain.	
6 Did the injury require hospitalization? [ ] Yes [ ] No Hospital name: Admission date: Discharge date:	7 Is additional hospitalization required? [ ] Yes [ ] No 8 Is medical evacuation overseas required? [ ] Yes, where ..... [ ] No
9 Surgery performed if any (please describe) /date performed:	10 Other treatment applied:
11 What permanent impairment do you anticipate?	12 Dates of treatment/confinement From:.....To: .....
13 Period of Disability, if applicable Partial Disability: from .....to:..... Total disability: from: ..... to:	14 Date employee can resume work Light work: ..... Regular work: .....

15 If employee can only resume light work, indicate extent of physical activity and limitations that could reasonably be performed. #15 continued……..				
16 Recommendations for future cure or treatment, if applicable				
17. Name and signature of physician		18. Specialization	19. Date of this report	
20 Medical/hospital charges, if any: Please provide extra sheet(s) if necessary				
Date	Services/supplies	Quantity	Unit Price	Amount

SCHEDULE 4

Form WCA – 300

COMPENSATION ORDER

Copy distribution: 1. Insurance carrier2. Claimant/worker 3. Employer 4. WCA file

This letter serves to confirm that the below-mentioned claim for worker's compensation benefits has been:

[ ] Approved [ ] Denied [ ] put on hold

1. Claim No.	2. Claimant's name:	3. Employer's name:

4. Nature/description of injury/illness	5. Date & Place where injury/illness occurred

6. Reasons for approval:

[ ] Injury, illness or death was caused by work related incident.
[ ] incident was corroborated by witness(es) and injury confirmed by attending physician.
[ ] disability falls within the eligibility requirements of the Workers' Compensation law.
[ ] required documents were submitted on time and found to be in order.
[ ] Other (Specify)

THE ADMINISTRATOR HEREBY ORDER THE FOLLOWING INSURANCE CARRIER TO PROCESS PAYMENT OF THIS CLAIM WITHIN 15 CALENDAR DAYS.

[ ] Moylan's Insurance [ ] Marshalls Insurance Agency [Self/Other……

7. Reasons for denial

[ ] injured worker is not covered by worker's compensation insurance policy.
[ ] injury, illness or death was not caused by work related incident.
[ ] worker's statements are doubtful or there was no witness who can confirm alleged injury/illness/death.
[ ] injury/disability does not fall within the eligibility requirements of the Workers' Compensation law.
[ ] injury does not have any significant impact on the worker's ability to perform his normal duties.
[ ] claim for worker's compensation was filed beyond the deadline of one year after the date of injury.
[ ] the new and additional evidence presented are not strong and convincing enough to change the previous decision of the Administrator to deny the claim for worker's compensation.
[ ] injured employee was excessively intoxicated at the time causing the incident.
[ ] there was willful intention of worker to injure/kill himself or others.

8. Reasons for claims being put on hold

[ ] the following requirements have not been satisfactorily met:
[ ] awaiting the outcome of a detailed investigation into the cause of the injury/illness/death
[ ] worker has not provided supportive medical evidence
[ ] worker's medical information is insufficient or the worker has refused to undergo medical examination by a physician.

	Date
_____ Administrator	

SCHEDULE 5

Form WCA -106

APPLICATION FOR SELF-INSURANCE

Date:

To: _____
Administrator
Marshall Islands Workers' Compensation Administration
P.O. 175, Majuro
Marshall Islands MH 96960

Dear Administrator_____,

In connection with the implementation of the Workers' Compensation Program starting October 1, 2023, _____ (indicate business name) would like to apply for self-insurance for the following reason(s) marked 1-6 (mandatory) with an X below:

1. [ ] Based on the attached financial report, I believe that _____ (indicate business name) will be able to meet its financial liabilities and can manage financial transactions necessary to make timely payments of compensation and reimbursements as required under the Worker's Compensation Act;

2. **Indicate whether the attached financial statements (F/S) are audited or not:**

   [ ] F/S are audited

   [ ] F/S are not audited

3. [ ]We have the necessary resources for the purpose of administering claims under the Workers Compensation Act;

4. [ ]We are providing the attached evidence to prove that we are actively monitoring the incidence and severity of work injuries arising from employment on all of our locations;

5. [ ]We are strictly and consistently implementing health and safety arrangements and practices to ensure the protection and security of our employees in the workplace;

6. [ ]Our management has a sound understanding of the supports required for the rehabilitation of injured employees to achieve their recovery and return to work, including providing suitable employment to employees who suffer work injuries.

7. [ ]Other eg unable to secure insurance (Explain in detail)

You may contact the undersigned for more information or requirement(s).

I hereby certify, under penalty of perjury that all information and answers that I provided are true and correct to the best of my knowledge and belief.

Name:_____ Signature:_____

Registered name of business: _____ Date:_____

NOTE. This document must be notarized and supporting financial report attached.

On this _____ day of _____, 20____, before me a notary public, the undersigned officer,

personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to this document, and acknowledged that he/she executed the same to the best of his/her knowledge and belief.

In witness hereof, I hereunto set my hand and seal.

NOTARY PUBLIC

SCHEDULE 6

WCA -201

APPLICATION FOR CLAIM OF COMPENSATION

Form WCA – 201 (Schedule 6 of the Workers' Compensation Regulations) **WORKER'S CLAIM FOR COMPENSATION** (To be filed within one year after date of injury/illness/death or date of last payment of "salary from employer"	
1. Name of injured worker/ SSS No.	2. Name of employer:
3. Worker's mailing address & contact no.	4. Employer mailing address & contact no:
5. Worker's Citizenship (for medical referral purposes):	6. With valid Health Card? [ ] Yes [No] MOH Health card expiry date:
7. Date & time of injury/illness/death:	8. Date of employer's first knowledge of injury:
9. Date & time worker stopped working due to injury/illness/death:	10. Date& time worker returned to work:
11. Date & time pay stopped:	12. Worker's regular weekly work schedule: [ ]Su [ ]M [ ]T [ ]W [ ]Th [ ]F [ ]Sa
13. Worker's occupation/role:	14. Worker's basic earnings + regular overtime: Hourly:$..... Daily: $.....
15. Was there someone else other than the worker that caused the incident: [ ] Yes [ ] No	Weekly: $..... Yearly: $.....
16. Describe in detail how the incident occurred. Tell what the injured worker was doing at the time of the incident. State if there was a witness during the incident and get his/her statement in writing. Name part of body affected, i.e. fractured leg, bruised arm, burnt face. Use additional sheet(s) if necessary.	
17. TYPE OF CLAIM FOR COMPENSATION [ ] Temporary disability (lost wages) [ ] Permanent disability (loss use of _____) [ ] Disfigurement (serious head/facial) [ ] Other :	Explain:

18. Did you receive treatment/medical attention? [ ] Yes [ ] No Date: From:..... to:.....	19. If yes, give name of treating physician and hospital
20. Name & signature of worker/date:	21. If worker can't fill-up this form, indicate name & signature of person completing this form
22. Medical Report attached	23. Date of Medical Report
24. Claim Number (from MISSA)	25. Filed by (MISSA)

SCHEDULE 7

NOTICE OF CONFIRMATION OF FILED CLAIM

Form WCA - 308

NOTICE OF FILED CLAIM

(To be issued by the Administrator within 10 days a claim was received)

Date:

To: Name of injured/ill/deceased worker
Address

Name of Employer
Address

Name of Insurance Carrier (if appropriate)
Address

Subject: Claim for Worker's Compensation, Re: [Name of Claimant]
Claim No:

Yokwe aolep,

Please be informed that on _____, we have received a claim for workers' compensation as follows:

Name of claimant worker	:
Name of employer	:
Date of injury/illness/death	:
Nature of injury/illness	:
Cause of death (if applicable)	:
Claim reference no.	:

Any party who has any objection to this claim may file a notice of objection within 14 days upon receipt of this notice, pursuant to the Workers' Compensation Regulations.

You may contact the undersigned for more information or clarification.

Sincerely,

_____
Administrator

SCHEDULE 8

NOTICE FOR HEARING OF CLAIMS

Form WCA - 301

NOTICE OF HEARING BY ADMINISTRATOR

Date:

To: Name of injured worker
Address

Name of Employer
Address

Name of Insurance Carrier
Address

Subject: Review/Dispute on Claim for Worker's Compensation, Re: Name of Claimant

Yokweaolep,

In connection with the review/dispute of/on claim for worker's compensation by the above-mentioned subject worker, we request your attendance to an informal meeting on _____, 2022, at _____(indicate the time). The meeting venue is MISSA's conference room at its head office in Majuro, Republic of the Marshall Islands. You will need to allow ____hours.

Please bring with you all pertinent documents and other evidence to support your position on this matter.

If you are unable to come in person, you may send your authorized representative to attend on your behalf. I require a letter of authorization to accompany any representative.

It is important to note that your or your authorized representative's attendance is required for the early resolution of this dispute. *Failure to do so on your part within 10 calendar days without any valid reasons(s) will be considered as final acceptance* to the decision of the Administrator as embodied in the Compensation Order issued on _____, 2022.

You may contact the undersigned for more information or clarification.

Sincerely,

Bill Joseph
Deputy Administrator & COO

SCHEDULE 9

ADMINISTRATOR'S AWARD OR ORDER FOR PAYMENT

Form WCA - 302

MEMORANDUM OF AGREEMENT & ADMINISTRATOR'S DECISIOM

Date:

To: Name of injured worker
Address

Name of Employer
Address

Name of Insurance Carrier
Address

Subject: Agreement during Informal Meeting on (indicate date), Re: Claim No _____, of Name of Claimant

Yokwe aolep,

Below is a summary of the agreement that was reached during the informal meeting held on _____ at the MISSA office in Majuro.

Brief description of the agreement: _____

Based on the statements and evidence presented by all parties, and the final settlement agreed upon, the undersigned has decided to:_____

To confirm with the above-mentioned agreement and facilitate final resolution of the claim, all parties in the meeting must sign below.

CONFORME:

_____ Worker/claimant

_____ Employer/representative & Position title

_____ Representative of Insurance carrier

_____ MISSA Administrator/Deputy Administrator

Form WCA - 303
MEMORANDUM OF DISAGREEMENT & ADMINISTRATOR'S DECISION

Date:

To: Name of injured employee
Address

Name of Employer
Address

Name of Insurance Carrier
Address

Subject: Disagreement during Informal Meeting on (indicate date) Re: Claim of (Name of Claimant) Claim No:

Yokwe aolep,

Below is a summary of the unsettled disputes that was/were raised during the informal meeting held on _____ at the MISSA office in Majuro.

Brief description of the disagreement: _____

Based on the testimonies of all parties and the evidence presented, the undersigned has decided to:_____. The Administration's decision was based on the following reasons and facts:

1. Recom 1
2. Recom 2

We are giving you fifteen (15) calendar days to respond if you disagree with the decision and make an appeal to the Workers' Compensation Board. Failure on your part to meet the deadline without a valid reason shall be considered as acceptance to the decision of the Administration.

Sincerely,

_____
Administrator

SCHEDULE 10

NOTICE OF COMMENCEMENT OR SUSPENSION OF PAYMENT

Form WCA -103

Notice of Payment or Suspension/Termination of Payment

This notice must be submitted by the insurance carrier to the Administrator within 15 calendar days after payment of compensation has been made. If payment is being suspended, or stopped for modification, and will later be reinstated, or continued, indicate in item 12 and give reasons. This form is to be used for disability or death benefits

1 Name of injured/ill worker:	2 Name of employer:	3 Check if applicable [ ] First Payment [ ]$_____weekly payment [ ]Final Payment [ ] Suspension of Payment [ ] Termination of payment
4 Worker's address	5 Employer's address	
6 Date of injury	7 Dateworker first lost pay due to Injury	8 Date when worker can return to work as per doctor's advice
9 Date worker actually returned to work	10 no. of available VL/SL hours	11 Date of 1st payment
12 Reason(s) for suspension or termination of payment		13 Date of last payment/notice served on worker

14 Summary of Disability Payments (use additional sheets if necessary)

Disability type	From	To	Amount/week	# of weeks	Total Amount
Total					

15 Other Expenses (Use additional sheets if necessary)
Name of DependentsAmountTotal

16 Name of insurance carrier	17 Address of Carrier	18 Date of this Notice
19 Name of person completing this report	20 Position title	21 Signature

SCHEDULE 11

Form WCP -501
(Schedule 11 of the Workers' Compensation Regulations)

NOTICE CONTROVERTING ACCEPTANCE OFCLAIM FOR COMPENSATION

To be filed by Employer or their insurer within 14 calendar days after the employer/insurer has learned about a pending claim or after receipt of Notice of Worker's Injury, Illness or Death. The contesting party must provide evidence to the MISSA Administrator supporting their argument to controvert (challenge) the claim by contradicting any part lodged by the employee (worker).

1 Name of employer/EIN:	2 Name of worker/Claim number:
3 Employeraddress & contact phone no.	4 Worker's address & contact phone no:
5 Worker's usual occupation or job role:	6 Date of first knowledge of injury/illness:
7 The undersigned hereby seeks the Administrator to make a decision to deny the claim for worker's compensation by the subject worker. THE EMPLOYER MUST STATE THE GROUNDS UPON WHICH THE ACCEPTANCE OF CLAIM TO COMPENSATION IS CONTESTED.I am submitting the following evidence as proof the concerns are valid: (use another sheet if necessary and attach to this form)	
8 Name, signature & title of person representing insurer	9 Name, signature& title of employer representative
10 Date of this Notice	11 Mail/Hand-deliver this notice to: **The Administrator** RMI Workers' Compensation Administration P.O. Box 175, Majuro MH 96960 Marshall Islands (MISSA Office)

SCHEDULE 12

PERSONAL DOCUMENTATION AND RELEVANT INFORMATION

Form WCA –206
PERSONAL DOCUMENTATION & RELEVANT DOCUMENTATION

(To be completed by the claimant, employer or insurer when required by the Administrator)

Date:

To: _____, MISSA/WCA Administrator

Subject: My claim for Worker's Compensation, Re: Name of Claimant : Claim No:

Yokwe Administrator,

In compliance to your request for personal documentation and relevant information, I have enclosed in this letter the following documents and information (marked X):

[ ] Birth certificate validated by the Ministry of Internal Affairs

[ ] Marriage certificate

[ ] Notarized affidavit of common law marriage

[ ] Death certificate validated by the Ministry of Internal Affairs

[ ] Medical Certificate or Medical Report relating to injury/illness

[…..] Proof of Identification (Photo)

[ ] Others (please specify)

You may contact me on phone …… for more information or clarification.

Sincerely,

Name of Claimant

Signature of Claimant

SCHEDULE 13

LUMPSUM PAYMENT

Form WCA – 203
(Schedule 13 of the Workers' Compensation Regulations)

Application for Lump-sum Worker's Compensation Benefit

This application can only be submitted by the Worker or his/her dependent to the Administrator after receipt of a Compensation Order and when the injury/illness has stabilized. In case of death, a copy of the death certificate must be attached to this form and submitted to MISSA.

1 Name, address and claim number of injured worker	2 Date of birth	3 Name of and address of employer
4 Claimant's Representative (if applicable) name and address	5 Insurer's contact details and address	
6 Date of injury/illness/death	7 Date worker first lost pay due to injury/illness	
8 Nature of injury/illness		
9 Date of death (if applicable)	10 Place of death (if applicable)	11 Name of beneficiary (if applicable)
12 Address of beneficiary (if applicable)	13 Estimated amount of lump-sum benefit	
14 Reason(s) for applying for lump sum benefit (attach evidence that the injury/illness has stabilized)		

Applicant's Declaration:

I hereby declare that a report of my injuries has been filed with the RMI Worker's Compensation Administrator. In lieu of the periodic payment of compensation, I hereby request the Administrator to authorize and approve a single lump sum payment of my compensation equal to the present value of the unpaid future payments due, in accordance with the computation provided by the Administrator.

I further declare that I understand fully that the liability of the employer and their insurer with respect to the compensation for this injury will be released upon approval of this application, and that no further compensation will be due to me, beyond the lump sum payment. Medical benefits in connection with this injury shall not be affected by approval of this request unless otherwise specified by the Administrator.

I further declare, under penalties of perjury, that the information contained in this application is true and correct to the best of my knowledge and belief.

15 Name of person completing this application	16. Signature of applicant	17 Date of this application
18 **Recommendation** of MISSA claims reviewing officer	19 Position title	20 Signature of MISSA Officer

SCHEDULE 14

DEFAULT OFPAYMENT

Form WCA - 204

NOTICE OF EMPLOYER'S/INSURER'S FAILURE TO PAY

Date:

To: [Name of Administrator]
Administrator
Marshall Islands Workers' Compensation Administration
P.O. 175, Majuro
Marshall Islands MH 96960

Dear Administrator [_____],

Please be advised that despite my demand to pay, my employer _____ or their insurer has failed to pay the worker's compensation due to me.
OR
The employer or their insurer has ceased paying me, despite being medically certified as unfit to return to full duties.

The details of the missed payments are as follows:

Claim ref. no.	:
Amount not paid	:
Due date	:
Date of Compensation Order	:
Nature of injury/illness	:
Date of injury/illness	:
Efforts made to seek payment	:

You may contact me on phone…… for more information or requirement(s).

Sincerely

Name of Claimant Signature of Claimant

SCHEDULE 15

EMPLOYER'S OBJECTION TO THE CLAIM

Form WCP -500
(Schedule 15 of the Workers' Compensation Regulations)

NOTICE CONTESTING CLAIM FOR COMPENSATION

To be filed by Employer or Insurance Carrier within 15 calendar days after receipt of Compensation Order approving the claim by the Administrator. The employer may contest the claim for compensation if it can show evidence, not previously provided, that it is not liable for the payment of compensation. This notice must be filed with the Administrator with documentation supporting the appeal for reconsideration.

1. Name of employer/EIN:	2. Name of worker/Claim number:
3. Employer address & contact phone no.	4. Worker's address & contact phone no:
5. Worker's usual occupation or job role:	6. Date of first knowledge of injury/illness:
7. The undersigned hereby appeals to the Administrator to reconsider her decision to approve the claim for worker's compensation by the subject worker. THE EMPLOYER MUST STATE THE GROUNDS UPON WHICH THE ACCEPTANCE OF CLAIM TO CONPENSATION IS CONTESTED.I am submitting the following new and additional evidence as proof that the concerns raised about this claim are valid: (use another sheet if necessary and attach to this form)	
8. Name, signature & title of person representing insurer	9. Name, signature& title of employer representative
10. Date of this Notice	11. Mail/Hand-deliver this notice to: **The Administrator** RMI Workers' Compensation Administration P.O. Box 175, Majuro MH 96960 Marshall Islands (MISSA Office)

SCHEDULE 16

WORKER APPEALLING DENIAL OF CLAIM

Form WCP – 202

(Schedule 16 of the Workers' Compensation Regulations)

NOTICECONTESTING DENIAL OF CLAIM FOR COMPENSATION

To be filed by the Worker or Representative within 15 calendar days after receipt of Compensation Order denying the claim by the Administrator. The Worker must provide evidence not previously presented to the Administrator supporting the appeal to the Worker's Compensation Board for reconsideration.

1.Name of worker/Claim number	2.Name of employer/EIN
3. Worker's address & contact phone no.	4. Employer's address & contact phone no:
5.Worker's occupation or job role	6.Date of first knowledge of injury/illness
7. The undersigned hereby appeals to the Workers' Compensation Board to reconsider the Administrator's decision denying the claim for worker's compensation. THE WORKER MUST STATE THE GROUNDS UPON WHICH THE DENIAL OF A CLAIM TO COMPENSATION IS CONTESTED (*see notes below). I am submitting the following new and additional evidence as proof that my/our claim is valid: (use another sheet if necessary and attach to this form)	
8. Name and signature of worker/claimant Name Signature	9. Date of this Notice
10. Name, signature & title of representative of worker Date:	11. Mail/Hand-deliver this notice to: **The Administrator** RMI Workers' Compensation Administration P.O. Box 175, Majuro MH 96960 Marshall Islands (MISSA Office)

SCHEDULE 17

Form WCA – 402

Insurance Carrier's Premium and Remittance Report

Name of Insurance Carrier	EIN Number	Address of Insurance Carrier

QUARTER	Premium written A	Premium collected B
1 1st quarter (January to March)		
2 2nd quarter (April to June)		
3 3rd quarter (July to September)		
4 4th quarter (October to December)		
5 Collections from the previous year		
6 Total of lines 1 thru 5		
7 Enter 2% of line 6, column B		
8 Deduct: payment(s) made on previous quarter(s)		
9 Amount due this quarter		
10 Penalty from late filing		
11 Total amount due		

INSTRUCTIONS:

1. Enter the January to March net policy written on Column A and the amount of premium in Column B;
2. Enter the April to June net policy written on Column A and the amount of premium in Column B;
3. Enter the July to September net policy written on Column A and the amount of premium in Column B;
4. Enter the October to December net policy written on Column A and the amount of premium in Column B;
5. Enter on Column B, the collections made from the previous year for which the 2% levy has not been paid;
6. Enter the total of lines 1 thru 5 in Column B;
7. Multiply the amount on Column B, line 6, by 2% and enter here;
8. Enter total payments made on previous quarter(s) on Column B;
9. Deduct the amount on line 8 from line 7, enter the difference here on Column B;
10. Penalty charges for late filing. Penalty is based on 12% per annum on unpaid amount; and
11. Enter the total of lines 9 and 10 in Column B. Make your check payable to the Marshall Islands Workers' Compensation Administration.

DEADLINES: 1st qtr. – April 30, 2nd qtr. – July 31. 3rd qtr. – Oct. 31, 4th qtr. – Jan. 31

Declaration: I declare under penalty of perjury that the information contained in this report is true and correct to the best of my knowledge.

_____ _____ _____

Name and signature Title Date

FOR WCA USE ONLY Received by:	Date filed	Official Receipt no.

SCHEDULE 18

EMPLOYERS' REPORT ABOUT THE CLAIM

Form WCA – 101

Employer's Report of Worker's Injury/Illness/Death

(To be submitted by the employer to the Administrator and Insurance Carrier within 10calendar days after date of injury or death). A copy of the certificate of compliance must be attached as proof that the injured or deceased worker is covered by a valid worker's compensation insurance policy.

Name of injured employee:	Name of employer:
Claim No:	EIN No:
Employee's address & contact no.	Employer address & contact no:
Citizenship:	With valid Health Card? [ ] Yes [No] Health card expiry date:
Date & time of injury or death:	Date of employer's first knowledge of injury or death:
Date & time employee stopped working due to injury/death:	Date& time employee returned to work:
Date & time pay stopped:	Employee's regular weekly work schedule: [ ]Su [ ]M [ ]T [ ]W [ ]Th [ ]F [ ]Sa
Employee's occupation:	Employee's basic earnings + regular overtime: Hourly:$..... Daily: $.....
Was there someone else other than the employee that caused the accident: [ ] Yes [ ] No	Weekly: $..... Yearly: $.....
Describe in detail how the accident occurred. Tell what the injured or deceased employee was doing at the time of the accident. State if there was a witness during the accident and get his/her statement in writing. Use additional sheet(s) as necessary.	
Nature of injury/illness (name part of body affected, i.e. fractured leg, bruised arm, burned face, etc.) Note: PLEASE ENCIRCLE THE APPROPRIATE ITEMS ON THE ATTACHED QUESTIONNAIRE	
Has medical attention been authorized? [ ] Yes [ ] No Date authorized:	Was insurance carrier notified? [ ] Yes [ ] No Date notified:
Name of attending physician/Hospital location	Name of insurance carrier:

SCHEDULE 19

EMPLOYER'S CERITIFICATE OF COMPLIANCE

Form WCA-100
Schedule 29

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. Premium	14. Effective date of policy..... 16. Expiration of policy.....

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.**[ ] Copy of insurance policy is attached**

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