NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: **West Virginia State Agencies**

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of **West Virginia**, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: **American Zurich Insurance Company**
1400 American Lane
Schaumburg, IL 60196-1056
800-987-3373

Policy Effective Dates: **7/1/2015 to 7/1/2016**

Policy Number: **WC 9314081-04**

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: **Zurich Claims Services**
PO Box 49547
Colorado Springs, CO 80949-9537

Claims Representative: _____

Claims Telephone: **800-987-3373**

Collecting Workers' Compensation benefits by intentionally misrepresenting, misstating, or failing to disclose any material fact is **fraud**. Fraudulent claims are subject to prosecution. All suspected violations will be investigated. Anyone may report a potentially fraudulent claim by contacting the Workers' Compensation Division or Attorney General's office.

Date Posted: _____