Certified Workplace Medical Plan

Consent to Participate

Return to cwmpenrollment@naico.com

or

FAX to 405-240-5591

Employer Name: _____

Address: _____

Phone: _____ **Fax:** _____

Workers' Compensation Contact: _____

Number of Employees: _____

Hours of Operation: _____

Type of Business: _____

Effective Date of Plan: _____

PLEASE FILL OUT COMPLETELY

Certified Workplace Medical Plan (Workers Compensation Act Title 85A O.S. sec 56)

This Company is participating in CorVel's CWMP

- Review your company's procedure for reporting an injury: Carrier/CorVel CWMP Injury Notification should take place within ***24-48 hours*** of the date of injury
- Post the CorVel workplace posters in appropriate locations throughout the company property (if applicable).

The Payor / Insurance Company: **National American Insurance Company**

Broker: _____

Automatically renewed one year from the effective date of this Agreement. This Agreement will be automatically renewed for consecutive 12-month periods, or until the employer's policy with the payor / Insurance company terminates. This agreement may be terminated without cause with a thirty (30) day written notice by either party.

_____ _____

Company Contact name, please print Date

_____

Company Contact Signature

_____ _____

CorVel Corporation Date