State of New Jersey
Department of Labor & Workforce Development
Division of Workers' Compensation

IMPORTANT WORKERS' COMPENSATION LAW NOTICE

$2500.00 A DAY FINE FOR FAILURE TO PROVIDE INSURANCE CARRIER OR SELF-INSURED EMPLOYER CONTACT PERSON FOR MEDICAL AND TEMPORARY DISABILITY ISSUES

P.L. 2008 Chapter 96, effective October 1, 2008, applies to **every workers' compensation insurance carrier and self-insured employer**. The law provides that:

> *Every carrier and self-insured employer shall designate a contact person who is responsible for responding to issues concerning medical and temporary disability benefits where no claim petition has been filed or where a claim petition has not been answered. The full name, telephone number, address, e-mail address, and fax number of the contact person shall be submitted to the division. Any changes in information about the contact person shall be immediately submitted to the division as they occur. After an answer is filed with the division, the attorney of record for the respondent shall act as the contact person in the case. Failure to comply with the provisions of this section shall result in a fine of $2,500 for each day of noncompliance, payable to the Second Injury Fund.*

In order to comply with this law, please complete this form and send the completed form to the Division. To submit the form, you must complete the form, save the form with your changes and then e-mail the saved form to OSCF@dol.nj.gov. The information you provide will be posted on the Division's website at the next update of the Contact List available to the public.

Note:

- **If the insurance carrier or self-insurer identified below has other subsidiaries and or affiliated companies authorized to operate in New Jersey, this form must be submitted for each of those entities.**
- **If you are an employer that has workers' compensation insurance coverage, there is no need to submit this form.**

Date: _____

Carrier or Self-Insurer Name: _____

I. Primary Contact Name (required):

Name: _____ **Job Title:** _____

Company: _____

Address: _____

Phone #: _____ **Fax #:** _____ **E-Mail Address:** _____

II. Secondary Contact Name:

Name: _____ **Job Title:** _____

Company: _____

Address: _____

Phone #: _____ **Fax #:** _____ **E-Mail Address:** _____