

## CA MPN

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To be completed by employer:

- Policyholder: \_\_\_\_\_
- Policy Number: \_\_\_\_\_
- Employer's Contact: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- MPN Effective Date \_\_\_\_\_

Follow these steps:

- Complete the DWC-7 form fields as required.
- Post the DWC-7 in an area readily accessible to all employees.
- Complete this form and return to Chubb via [CA MPN Mail@Chubb.com](mailto:CA_MPN_Mail@Chubb.com).
- Provide employees with the Employee Packet at the time an employee reports a work-related injury or condition.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed