



## CAMPN

To be completed by employer

Policyholder:	<input type="text"/>	Policy Number:	<input type="text"/>
MPN Effective Date:	<input type="text"/>		
Employer's Contact Person:	<input type="text"/>		
Phone Number:	<input type="text"/>	Email Address:	<input type="text"/>

- 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 email to [CA\\_MPN\\_Mail@Chubb.com](mailto:CA_MPN_Mail@Chubb.com) with a copy to [CA-MPN-Notification@corvel.com](mailto:CA-MPN-Notification@corvel.com).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Employer

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

\_\_\_\_\_  
Date Signed *(Effective MPN)*