



Thank you for choosing The Hanover for your Workers' Compensation needs. We are pleased to provide you with some information regarding future filing of claims, and other state specific information that will assist you with your claims reporting. You will find this information in the enclosed packet.

The Hanover has four methods for reporting new workers' compensation losses:

Phone In: Call 1-800-628-0250, follow prompts for reporting WC new losses.

Fax In: Fax completed First Report to 1-800-762-7788

Online: www.hanover.com Choose "Report a Claim" at the top of the page, then choose "Workers' Compensation Claim" under Business Claims.

E-Mail: E-mail completed First Report of Injury to WCNEWLOSSES@hanover.com

All four options are available 24 hours per day, 7 days per week. Upon receipt and entry of your claim into our system, your agent will receive a notification of the claim for their records. This occurs within 1 business day of receipt of your report.

The most essential part of a workers' compensation claim is prompt notification to us to allow prompt investigation, payment of benefits to your injured worker if appropriate, and to avoid any potential for late filing penalties that may be assessed by your state.

Welcome to The Hanover.

We look forward to working with you.

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE**The Employee Should:**

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

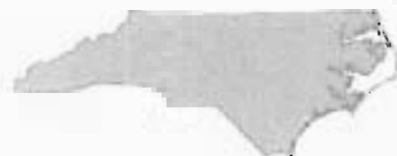
The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed \$2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

**For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov**

**NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335**

Website: www.ic.nc.gov



TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.

This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

*Emp. Code # _____

*Carrier Code # _____

Employer FEIN _____

Carrier File # _____

***Required Information.**

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name _____			Employer's Name _____			Telephone Number _____		
Address _____			Employer's Address _____			City _____	State _____	Zip _____
City _____	State _____	Zip _____	Insurance Carrier _____			Policy Number _____		
Home Telephone _____			Carrier's Address _____			City _____	State _____	Zip _____
Social Security Number _____			Carrier's Telephone Number _____			Fax Number _____		

Employer	1. Give nature of employer's business _____
	2. Location of plant where injury occurred County _____ Department _____ State if employer's premises _____
Time And Place	3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	5. Was employee paid for entire day _____ 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____
Person Injured	9. Occupation when injured _____
	10. (a) Time employed by you _____ (b) Wages per hour \$ _____
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____ (d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per
Cause And Nature Of Injury	12. Describe fully how injury occurred and what employee was doing when injured _____ (Statement made without prejudice and without vouching for correctness of information)
	13. List all injuries and specify body part involved (e.g. right hand or left hand) _____
	14. Date & hour returned to work / / at : _____ M. 15. If so, at what wages \$ _____ per
	16. At what occupation _____ 17. Employee's salary continued in full? _____
Fatal Cases	18. Was employee treated by a physician _____
	19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log: _____	Date Hired: / /	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility: _____	Address: Street/City/Zip/Telephone _____		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY	
RESEARCHER: _____	
CC: _____	
EC: _____	
DATA ENTRY: _____	

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un periodo de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un periodo de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED
PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

EMPLOYER: THIS MUST BE *PROMINENTLY* POSTED. I. C. RULE 201.

WORKERS' COMPENSATION NOTICE
And Instructions to Employers and Employees

All employees of this business suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier, except specifically excluded executive officers.

—IMPORTANT THINGS TO DO IN CASE OF INJURY OR OCCUPATIONAL DISEASE—

The Employee Should:

1. Immediately give the employer notice in writing of injury or occupational disease. Failure to inform the employer within thirty (30) days after an injury or the development of most occupational diseases, or the refusal to accept medical services provided by the employer, may deprive the employee of the right to compensation.
2. File claim with the Industrial Commission within two (2) years of the accidental injury or two (2) years after the death, disability or disablement caused by an occupational disease. (The Commission's Form 18 may be used to give notice to employer and to file a claim.) In case of fatal injury, claim must be filed by one or more dependents or next of kin of the deceased employee within two years after such death.
3. If no agreement is reached with the employer with regard to payment of compensation for injury or occupational disease, or if a disagreement develops over compensation due, the employee should promptly request the Industrial Commission to hold a hearing to decide the issues. Benefits may be denied if the request is made more than two (2) years after the date of injury or last payment of cash compensation.

The Employer Should:

1. Provide all necessary medical, surgical, hospital and rehabilitation services reasonably required to effect a cure, give relief and lessen the period of the employee's disability. N.C.G.S. §97-25. Keep a record and report to insurance carrier/compensation administrator ALL injuries suffered by its employees on the Commission's Form 19. The employer, or the carrier/administrator on its behalf, must mail a Form 19 report to the Industrial Commission within five (5) days of the occurrence or report of an injury causing more than one day's absence from work or \$2,000.00 or more in medical treatment, other than treatment provided at the work place. N.C.G.S. §97-92.
2. Pay compensation in accordance with the provisions of the Workers' Compensation Act for disability. Agreements between employer and employee to pay compensation must be submitted to the Industrial Commission for approval.

Información sobre alivio medico y monetario para heridas ocurriendo al lugar del trabajo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
(919) 807-2500

EMPLEADOR: ESTA INFORMACIÓN DEBE ESTAR *PROMINENTEMENTE* VISIBLE.
REGLA 201 DE LA COMISIÓN INDUSTRIAL

INFORMACIÓN SOBRE COMPENSACIÓN LABORAL

Instrucciones para Empleadores y Empleados

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, exento oficiales ejecutivos expresamente excluidos.

—INFORMACIÓN IMPORTANTE EN CASO DE UNA LESIÓN O ENFERMEDAD OCUPACIONAL—

El empleado deberá:

1. Notificar inmediatamente por escrito al empleador sobre la lesión o enfermedad ocupacional. El no informar al empleador dentro de los treinta (30) días después de una lesión o desarrollo de una enfermedad ocupacional, o el rehusar servicios médicos provistos por el empleador, pueden privar al empleado del derecho a compensación.
2. Hacer un reclamo a la Comisión Industrial (Industrial Commission) dentro de los dos (2) años de ocurrir el accidente o lesión, o dos (2) años después de la muerte, incapacidad o incapacitación causada por una enfermedad ocupacional. (Forma 18 de la Comisión puede ser utilizada para dar notificación al empleador y hacer el reclamo en la Comisión.) En caso de una lesión fatal, el reclamó deberá ser hecho por uno o más dependientes o herederos del empleado dentro de los dos (2) años después de la muerte del empleado.
3. Si no se llega a un acuerdo con el empleador en relación al pago de compensación por lesión o enfermedad ocupacional, o si hay un desacuerdo en cuanto se debe de la compensación, el empleado lo mas pronto possible debe pedir una audiencia a la Comisión Industrial para que decidan sobre los méritos del caso. Los beneficios pueden ser negados si la petición se hace después de dos (2) años de la fecha de la lesión o de el último pago de compensación.

El empleador debe:

1. Proveer todo servicio de hospital, médico, quirúrgico, y servicios de rehabilitación necesarios para la cura, el alivio y la minimización del período de incapacitación del empleado. N.C.G.S. §97-25. Mantener un archivo y reportar a la compañía de asegurado/administrador de compensación TODAS las lesiones ocurridas a sus empleados usando la Forma 19 de la Comisión. El empleador, o el portador de seguro deben enviar por correo la Forma 19 a la Comisión Industrial dentro de los cinco (5) días de ocurrido el reporte de una lesión que causa la ausencia del empleado por más de un (1) día o \$2,000.00 o más en tratamiento médico, excluyendo tratamientos provistos en el trabajo. N.C.G.S. §97-92.
2. Pagar compensación al empleado de acuerdo con lo provisto en el la Ley de Compensación Laboral para incapacidad. Los acuerdos de pago de compensación entre empleador y empleado deberán ser sometidos a la Comisión Industrial para su apruebo.

Información sobre alivio médico y monetario para lesiones ocurridas en el empleo.

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