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.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 250-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(Please read the instructions on page 2 for completing this form)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
		☐ Yes ☐ No	

Employer Mailing Address	City	State	Zip Code	Employer FEIN
			-	-

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
	-

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals	☐ Room	☐ Tips
		No. of Meals/wk.	No. of Days/wk	Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of Full-Time Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:		
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse	☐ Failure to Use Safety Devices	☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

SUPPLEMENTARY REPORT ON ACCIDENTS AND INDUSTRIAL DISEASES

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/wc
e-mail: DWDDWC@dwd.wisconsin.gov

SUBMIT THE WKC-12 WITH THIS REPORT IF IT WAS NOT PREVIOUSLY SUBMITTED.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

1. Name of Injured Employee			2. Social Security Number
3. Address	City	State	Zip Code

4. Injury Date	5. Last Day Employee Worked	6. Nature of Injury or Illness

7. Employer Name	8. Address (City, State and Zip)

9. Insurance Carrier (Not TPA or Adjuster) ☐ Check if employer is self-insured	10. Insurer Claim Number	11. N.A.I.C. Number

12. Insurer's Claim Handling Address	City	State	Zip Code

13. Date & Type of First Compensation Payment Type: ☐ TTD ☐ TPD ☐ Salary Cont'd ☐ Other Date:	14. Amount of 1st payment $	15. Weekly Wage Used to Set TTD Rate: $ ☐ Rate below max. - WKC-13-A attached ☐ WKC-13-A not attached - Estimated date it will be sent is:	16. TTD Rate: $

17. If 1st Payment Was Late, (more than 14 days after injury date) State Reason:

18. Remarks: ☐ Denied ☐ Being Investigated (Attach Copy of Denial Letter) ☐ Suspended -- Lack of Medical Information ☐ Suspended -- Other Reason (Attach Copy of Suspension Letter)

Date Final Medical Report required under DWD 80.02(2)(e) 4 is anticipated:

☐ Other Remarks (Specify):

	Payment Period						
19. Type of Payment	20. Last Day of Work	21. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	25. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							
☐ TTD ☐ TPD ☐ Other:							

27. Amount of Permanent Partial Disability due:
(Attach supporting medical report if not previously submitted.)
Wks. @ $ = $

Indicate amount of PPD paid to date:
$

28. Final Indemnity Payment Date Type of Payment: Date of Payment:	29. Has the worker returned to work with wages at 90% or more of wages at the time of injury? ☐ Yes ☐ No

30. Report Prepared By	31. Work Phone No. ( ) -	32. Position	33. Date Signed

Under DWD 80.02(2), for injuries which require the first report of injury, self-insured employers and insurance companies shall submit:

- A supplementary report on a form WKC-13 on or before 30 days following that on which the injury occurred.
- Make a report within 7 days from the date that payments are stopped for any reason. If any payments are stopped for a reason other than the employee's return to work, provide an explanation to the department and the employee. The insurer shall advise the employee as to the reason for stopping payments, what the employee must do to reinstate payments, and the worker's rights to a hearing.
- Make a report on form WKC-13 with a copy to the employee when payment of compensation is changed from temporary total disability or temporary partial disability to a permanent disability.
- Include a copy of the WKC-13-A with the WKC-13 for claims where the wage is less than maximum, or provide an estimated date if the wage information is not available at the time the WKC-13 is submitted.
- Make a final report on a form WKC-13 within 30 days of when final payment of any type of compensation has been made. A practitioner's report is due if temporary disability exceeds 3 weeks or if permanent disability has resulted. The final medical report showing the extent of permanent disability and the end of healing is due within 30 days after the date that payment of final compensation is made. If you are unable to obtain one, you must submit a notice explaining why you are unable to obtain one or the date you anticipate submitting one. If the original medical report was not that of the treating practitioner, a treating practitioner's report is necessary if temporary disability exceeds 3 weeks or if permanent disability has resulted. A copy of information contained in the final WKC-13 report and the final practitioner's report must be sent to the employee.

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM:

Items 1 thru 11. Fill in all blanks completely.

Item 12. Fill in the mailing address of the office or adjusting company that makes the payments. All correspondence regarding this injury will be mailed to the insurer's designated claims handling address.

Items 13 thru 16. Fill in all blanks completely. If salary/wage is continued, check the box and include the weekly amount of salary in Item 15. If first payment covered temporary partial disability, check the box in Item 13. Include a WKC-13A for TPD if TTD rate is less than minimum.

Item 17. If the first payment was made more than 14 days after the date of injury or the day the employee left work prior to the first day for which WC is paid, give reason for the delay in payment.

Item 18. If payments are suspended for any reason other than return to work, state the reason. Explain unusual circumstances under "other remarks." If benefits are denied, be sure to include a copy of the denial letter to the worker. Enter the date the final medical report is anticipated if one is required under DWD 80.02(2)(e)4 and is not attached or previously sent. A final treating practitioner's report is due if there is any permanent disability or more than 3 weeks of temporary disability paid, including TPD or salary/wage continued.

Item 19. Check the appropriate box for the type of temporary total disability paid using sections 1-4 or attach another form if there are more payment periods of temporary total (TTD) or temporary partial disability (TPD) paid. If permanent partial disability (PPD), salary continued, vocational rehabilitation or any other types of payments were made, indicate the payment type under "other".

Items 20 and 21. Enter the last day of work and the return to work or end of healing dates. Do not enter the return to work or end of healing date unless the type of compensation paid for that period has been suspended.

Item 22. Enter the number of holidays paid by the employer and not paid WC for each period of disability.

Item 23. Enter the number of whole weeks and days paid TTD or, if TPD, the number of days for which TPD was paid. Any part of one day paid is considered a whole day for TPD purposes.

Items 24 and 25. Enter the rates and compensation paid that applies to the weeks or days in items 20-23.

Item 26. Enter the cumulative total of compensation paid for that line, items 19-25.

Item 27. Enter the number of weeks due, the permanent partial disability rate, and total compensation due for the disability. (Follow Sec.102.52, 102.53, and 102.55 where applicable.) Attach supporting medical information if it was not previously submitted.

Item 28. Enter the date of the final payment of temporary compensation if the claimant has returned to work or has been released for work and all temporary compensation due has been paid. Enter the date of final payment of PPD or other type of payment.

Item 29. Check the appropriate box if all temporary compensation has been paid and a date in item 28 has been entered.

Sample of Items 19 – 26

	Payment Period						
19. Type of Payment	22. Last Day of Work	23. Date of Return to Work or End of Healing (Do not enter if TTD or TPD continues to be paid)	22. No. of Employer Paid Holidays	23. No. of Weeks and/or Days Paid	24. Rate	26. Amount of Comp. Paid	26. Accumulated Total Amount Paid
☒ TTD ☐ TPD ☐ Other:	2/1/99	6/6//99	3	17+2 days	$ 538.00	$ 9,325.32	$ 9,325.32
☐ TTD ☒ TPD ☐ Other:	6/6/99	8/8/99	0	9	$ 220.00	$ 1,980.00	$ 11,305.32
☐ TTD ☐ TPD ☒ Other: Salary Cont'd	8/8/99	9/6/99	0	4	$ 538.00	$ 2,152.00	$ 13,457.32
☐ TTD ☐ TPD ☒Other: Vocational Rehab	9/6/99	12/21/99	0	15	$ 538.00	$ 8,070.00	$ 21,527.32

State of Wisconsin
Department of Workforce Development

Information for Employees on Wisconsin's Worker's Compensation

Worker's Compensation is a benefit program that pays for medical treatment and wages lost due to injuries or illnesses that happen at work.

What do you do if you are injured?

- Report any injury or illness to your employer as soon as possible. Provide as much detail and information about how the injury happened and the nature of your injury. Your employer will report your injury to their insurance carrier or claims administrator.
- Get medical treatment as soon as possible. You have the right to choose any physician licensed and practicing in this state to treat your work-related injury or illness. Your employer/insurance carrier will have access to the medical records involved in the injury.

What does worker's compensation pay for?

- Medical treatment resulting from your work-related injury or illness.
- Compensation for wages lost from the employer of injury including partial benefits if you return to work part-time or to a different job at a lower rate of pay.
- Compensation for permanent disabilities resulting from the injury or illness.
- Vocational Rehabilitation assistance to help you find other work or train you if you cannot return to work for your employer in suitable employment.

What will happen when you file a claim?

- Your claim will be promptly reviewed to determine that your injury is work related.
- Your employer/insurance carrier will pay your lost wage compensation, generally within 14 days after your injury, or they will notify you that your claim has been denied.
- If you disagree with the decision by your employer/insurance carrier and cannot resolve a dispute, you may contact your attorney or the Worker's Compensation Division for information about your appeal rights, which may require requesting a hearing with the Worker's Compensation Division.

Fraudulent Claims

Collecting worker's compensation benefits by intentionally misrepresenting, misstating, or failure to disclose any material fact is fraud. Fraudulent claims are subject to prosecution. All suspected violations will be investigated. Anyone may report a potential fraudulent claim by calling the Worker's Compensation Division at (608) 261-8486.

Questions and Contact Information

Worker's Compensation Division
P O Box 7901
Madison, WI 53707-7901
Telephone: 608 266-1340

Website: http://www.dwd.state.wi.us/wc/
E-mail: dwddwc@dwd.state.wi.us
Fax: (608) 267-0394

If you have a disability and need information in an alternate format, or need it translated to another language, please contact (608) 266-1340 voice or 1-866-265-3142 TTY.

WKC-14306-P (N. 08/2004)

221-8791 (1/12)

State of Wisconsin
Department of Workforce Development

Información para empleados sobre el Programa de Compensación de Trabajadores de Wisconsin

La Compensación de Trabajadores ("Worker's Comp.") es un programa de beneficios que paga el tratamiento médico y el salario perdido debido a una lesión o enfermedad que sucedio en su trabajo.

¿Qué debe hacer usted si se lesiona?

- Informe a su empleador de toda lesión o enfermedad lo mas pronto posible. Proporcione la mayor cantidad de detalles e información sobre la forma en que se produjo la lesión y el tipo do su lesion. Su empleador informará de la lesión a la empresa aseguradora o al administrador de solicitudes de reembolso.
- Obtenga tratamiento médico lo más pronto posible. Usted tiene derecho a escoger a cualquier médico licenciado que ejerza en este estado para que se encargue del tratamiento de la enfermedad o lesión relatado a su trabajo. Su empleador/empresa aseguradora tendrán acceso a los antecedentes médicos relacionados con la lesión.

¿Qué es lo que paga la compensación de trabajadores?

- El tratamiento médico debido a la enfermedad o lesión laboral.
- Compensación del salario perdido debido a la lesión, incluyendo los beneficios parciales si usted regresa al trabajo en jornada parcial o a un empleo distinto con un salario más bajo.
- Compensación por discapacidades permanentes que resulten de la lesión o enfermedad.
- Asistencia de rehabilitación vocacional para ayudarle a hallar otro empleo o entrenarlo si no puede volver a trabajar con su empleador en un trabajo adecuado.

¿Qué sucederá cuando presente una solicitud de reembolso?

- Se revisará oportunamente su solicitud para determinar si la lesión es relatado es su trabajo.
- Su empleador/empresa aseguradora le pagará la compensación por salario perdido, por lo general dentro de 14 días después de su lesión, o le notificará que su solicitud ha sido rechazada.
- Si usted no está de acuerdo con la decisión tomada por su empleador/empresa aseguradora y no puede resolver la disputa, puede comunicarse con su abogado o la División de Compensación de Trabajadores para obtener información sobre sus derechos de apelación, lo cual puede pedir que se solicite una audiencia ante la División de Compensación de Trabajadores.

Solicitudes de reembolso fraudulentas

Colectando beneficios de compensación de trabajadores mediante representar aml o declaraciones falsas, o el no divulgar ningún hecho importante constituye fraude. Las solicitudes de reembolso fraudulentas ameritan acciones penales. Se investigarán todas las infracciones sospechosas. Para denunciar una solicitud de reembolso fraudulenta llame a la División de Compensación de Trabajadores al (608) 261-8486.

Preguntas e información de contacto

División de Compensación de Trabajadores
P O Box 7901
Madison, WI 53707-7901
Teléfono: 608 266-1340

Sitio en Internet: http://www.dwd.state.wi.us/wc/
Correo electrónico: dwddwc@dwd.state.wi.us
Fax: (608) 267-0394

Si usted es una persona discapacitada y necesita información en un formato distinto, o que se la traduzcan a otro idioma, llame al (608) 266-1340 (voz) ó al 1-866-265-3142 (TTY).

WKC-14306-S-P (N. 08/2004)

221-8792 (1/12)