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.

MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and **[select one]** [has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer], or [maintains workers' compensation insurance coverage with the following:]

THE HANOVER INSURANCE COMPANY

(Name of insurance carrier or self-insurance group)
440 LINCOLN ST., PO BOX 15063, WORCESTER, MA 01615

508-855-1000

(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

Trends International LLC

(Name of third party claims administrator or claims office)
5188 W 74st, Indianapolis, IN 46268

317-388-4007

(address & phone number)

III. This workers' compensation coverage is effective for the following period: 05/15/2014 to 05/15/2015.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

Carol Kilgore, CPP

(Name of employer contact person)

Sr HR - PR Manager

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

COMPENSACIÓN AL TRABAJADOR DE MISSISSIPPI

NOTIFICACIÓN DE COBERTURA

I. Por favor tome nota que su Empleador está en cumplimiento con los requisitos de la Ley de Compensación al Trabajador de Mississippi, y **[seleccione uno]** [ha sido aprobado por la Comisión de Compensación al Trabajador de Mississippi para actuar como asegurador de sí mismo], o [mantiene seguro de compensación al trabajador con el siguiente:]

THE HANOVER INSURANCE COMPANY
(Nombre del asegurador o grupo de seguro propio)
440 LINCOLN ST., PO BOX 15063, WORCESTER, MA 01615
508-855-1000
(dirección y número de teléfono)

II. Los reclamos individuales de compensación al trabajador serán entregados y procesados por:

Trends International LLC
(Nombre del administrador de reclamos de terceros u oficina de reclamos)
5188 W 74th St, Indianapolis, IN 46268
317-388-4007
(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:
05/15/2014 hasta 05/15/2015.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

Carol Kilgore, CPP
(Nombre de la persona de contacto del empleador)
Sr HR-PR Manager
(Título y departamento o división)

V. Por favor tenga presente que cualquier persona que intencionalmente hace cualquier declaración o representación falsa o engañosa con el propósito de obtener o retener erróneamente cualquier beneficio o pago bajo la Ley de Compensación al Trabajador de Mississippi puede ser acusado de infracción de Miss. Code Ann. §71-3-69 (Rev. 2000) y al ser condenado será sujeto a las penas provistas en ella.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ MALE (M)

☐ FEMALE (F)

☐ UNKNOWN (U)

MARITAL STATUS

☐ UNMARRIED/SINGLE/DIVORCED (U)

☐ MARRIED (M)

☐ SEPARATED (S)

☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE

PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER.

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT (0) ☐

MINOR: BY EMPLOYER (1) ☐

MINOR CLINIC/HOSP (2) ☐

EMERGENCY CARE (3) ☐

HOSPITALIZED > 24 HRS (4) ☐

FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR INSTRUCTIONS