



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.

WORKERS' COMPENSATION ACT

If You Are Injured At Work Si Se Lastima En El Trabajo

1) Notice -- In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) You have the right to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) Claims information -- Contact your employer's Claims Representative.

1) Aviso. -- En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) Información acerca de Reclamaciones. -- Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name:

Phone #:

Address:

— The Hanover Insurance Company
— 440 Lincoln Street P.O. Box 15063
— Worcester, MA 01615
— (508) 855-1000

Note: Employer must fill in this insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than 7 days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Las Cruces:	Las Vegas:	Lovington:	Roswell:	Santa Fe:
1-800-255-7965	1-800-568-7310	1-800-870-6826	1-800-281-7889	1-800-934-2450	1-866-311-8587	1-505-476-7381
1-505-841-6000	1-505-599-9746	1-505-524-6246	1-505-454-9251	1-505-396-3437	1-505-623-3997	

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: www.workerscomp.state.nm.us

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

G E N E R A L	EMPLOYER (NAME & ADDRESS (INCL ZIP))		CARRIER / ADMINISTRATOR CLAIM #		OSHA LOG NUMBER		REPORT PURPOSE CODE		
	JURISDICTION		JURISDICTION CLAIM NUMBER						
	INSURED REPORT NUMBER								
	PHONE NUMBER		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #	
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
		CARRIER FEIN		POLICY / SELF-INSURED NUMBER		ADMINISTRATOR FEIN			
		AGENT NAME & CODE NUMBER							
		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE							
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		
	ADDRESS (INCL ZIP)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		OCCUPATION/JOB TITLE OR (SOC) CODE		
	PHONE NUMBER		# OF DEPENDENTS				EMPLOYMENT STATUS		
							NCCI CLASS CODE		
W A G E	RATE		PER	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER	# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?	
								<input type="checkbox"/> YES <input type="checkbox"/> NO	
								DID SALARY CONTINUE?	
								<input type="checkbox"/> YES <input type="checkbox"/> NO	
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF INJURY / ILLNESS CODE			PART OF BODY AFFECTED CODE	
	DEPARTMENT OR LOCATION 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 THE 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								
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT	
								<input type="checkbox"/> NO MEDICAL TREATMENT	
								<input type="checkbox"/> MINOR: BY EMPLOYER	
								<input type="checkbox"/> MINOR CLINIC/HOSPITAL	
O T H E R	WITNESSES (NAME & PHONE #)							<input type="checkbox"/> EMERGENCY CARE	
								<input type="checkbox"/> HOSPITALIZED > 24 HRS	
								<input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				

NM WCA FORM E1.2

EQUIVALENT TO OSHA'S FORM 301

FORM IA-1 (7/02) © IAIABC 2002

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000

In-State Toll Free: 1-800-255-7965

FARMINGTON: 505-599-9746/1-800-568-7310

LAS CRUCES: 505-524-6246/1-800-870-6826

LAS VEGAS: 505-454-9251/1-800-281-7889

LOVINGTON: 505-396-3437/1-800-934-2450

Roswell: 505-623-3781

Santa Fe: 505-476-7381

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to \$1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication *Guide to Completing the Employer's First Report of Injury or Illness*, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits*.

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).