

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.



Insurer: Trends International LLC
Street and Number: 5188 W 74 th St
City: Indianapolis State: IN Zip Code: 46268
For the period from: $5-15-14$ Through: $5-15-15$
Adjusting Company: Hanover Insurance
Street and Number: 440 Lincoln St,
City: Worcester State: MA Zip Code: 0/6/5 Telephone: 508-855-100
This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act.
Employer: Trends International LLC
By: Carol Kilgore, CPP
Title: S- HR-PR Manager
Witness: Lisa Algandu
Witness: Kell-Perry

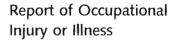
Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE 3301 Eagle Street Suite 304 Anchorage AK 99503 (907) 269-4980

FAIRBANKS 675 Seventh Avenue Station K Fairbanks AK 99701-4586 (907) 451-2889 JUNEAU PO Box 115512 1111 W 8th St Room 305 Juneau AK 99811-5512 (907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.





ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT Division of Workers' Compensation P.O. Box 115512, Juneau AK 99811-5512

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AWCB	Case	NU	mber	(Division	Use	Only):

EMPLOYEE: Answer ALL questions 1-20, sign, and give to your employer immediately.								
1. Last Name	First Name	Initial	2. Telephone Number	3. Date of Birth	4 Sex	5. Social Security No.		
6. Mailing Address		Total Control of the	7. Residence Address	1	-			
6a. City	State	Zip Code	7a. City		State	Zip Code		
8. Place (City/Town/Village/	Camp) Where Injury/Occupation	Date of Injury or Exposure to Disease			Employer's Premises?			
11. Name and Address of A	ttending Physician	12. Hospitalization In-Patient? 13. Name of Hospital						
City	State	Zip Code	City State Zip Code					
14. Describe Part(s) of Body Injured/Nature of Occupational Illness 🗀 Left 🗀 Right 15. Describe how the Injury or Occupational Illness happened								
information concerning a will be used to evaluate zation is valid for a one-	ovide my employer (named in bo any health care advice, testing, tre my entitlement to receive benef year period from the date of my this authorization is as valid as th	atment, or supplies its, including payme signature (box 17a)	provided to me for the injur nt of medical benefits, unde	y or illness describe er the Alaska Work	ed above in kers' Compe	box 14. This information ensation Act. This authori-		
	for Signature, Explain Circumstar				17a, Date	e Signed		
EMPLOYER: 18. Employer's Name	Review emp	loyee answers	18-20, answer question 19. Employer's Alaska Ac		from Mailin	g)		
						· · · · · · · · · · · · · · · · · · ·		
20. Employer's Mailing Add	ress (Street and Number)	21. Name of Insurer						
20a. City	State Zip Code	22. Full Name and Address of Adjusting Company						
23. Date Employer First Knew of Injury	24. Date/Time (AM/ Employee Left V	22a. Mailing Address (Street and Number)						
25. Off Work After Injury/Illness? ☐ Yes ☐		Death?□Yes□No Date	22b. City	State	Zip Code	22c Telephone		
28. Location Where Injury of	or Occupational Illness Happened	j	29. Employee's Occupation	OFF	30. Da	ste Hired by Employer		
31. Earnings. Calculated By	32. Rate of \$,	ys Employee Works per We 3 or Less □4 □5 □6 □	Carlotte and the carlot	e Scheduled	d Days Off		
35. Workday Began 3 □ AM □ PM	6 Employee Paid for Day Injured or III? Yes No	37. Federal EIN #	38. Give Details of How	Injury or Illness Ha	ppened			
39. Injury/Illness Duc to Ma Product Failure? ☐ Yes		41. List Any Machine/Substance/Object 42. If Machine, What Part Causing Injury						
43. Name and Address of V	Vitnesses	M Injury/Mness Caused by Anyone Besides Employee, Give Name and Address						
46. If You Doubt Validity of	Injury or Illness, State Reason							
47. Signature of Authorized	Employer or Representative	48. Title 49. Date Signed						