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.

Minnesota Workers' Compensation Employee rights and responsibilities

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

If you are injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

What does workers' compensation pay for?

- Medical care for your work injury, as long as it is reasonable and necessary;
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start);
- Compensation for permanent damage to or loss of function of a body part;
- Benefits to your spouse and/or dependents if you die as a result of a work injury;
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.

What the insurance company must do:

- Investigate your claim promptly;
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name:	THE HANOVER INSURANCE COMPANY	Phone number:	(508) 855-1000

If the insurer *accepts* your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer *denies* your claim for wage-loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than $500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

If you have questions or need more help, call the Minnesota Department of Labor and Industry:

Workers' Compensation Hotline
1-800-DIAL-DLI
(1-800-342-5354)
8 a.m. to 4:30 p.m.,
Monday-Friday

Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
Phone: (651) 284-5032
TDD: (651) 297-4198

Department of Labor and Industry
Workers' Compensation Division
525 Lake Ave. S., Suite 330
Duluth, MN 55802-2368
Phone: (218) 733-7810
Toll-free: 1-800-342-5354

Your call will be answered by experienced workers' compensation specialists who will provide **instant, accurate information and assistance.** Additional workers' compensation information is available on the department Web site at *www.dli.mn.gov*.

September 2008

This document can be made available in alternative formats, such as Braille or audio, by calling (651) 284-5042 or (651) 297-4198/TDD.

221-8788 (1/12)

MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

FRO 1

DO NOT USE THIS SPACE

1. **EMPLOYEE SOCIAL SECURITY #**	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. **DATE OF CLAIMED INJURY**	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. **EMPLOYEE** Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City / State / Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. First date of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No / 32. RTW with restrictions ☐ Yes ☐ No

33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated
35. Certified Managed Care Organization (if any)	

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
City / State / Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City / State / Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN	52. CA address	
48. Policy # (including effective dates) or self-insured certificate #	City / State / Zip Code	
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the CA:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (see Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name and Federal Employer Identification Number (FEIN) of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's FEIN.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.
- Item 55: These items apply only to FROIs electronically submitted by the claim administrator.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.