The Hanover Insurance Group

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.

KANSAS
DEPARTMENT OF LABOR

NOTICE: Employers are required to provide this information to each injured worker.

Information for Injured Employees

Division of Workers Compensation
OMBUDSMAN/CLAIMS ADVISORY UNIT
800 SW Jackson Street, Suite 600
Topeka, KS 66612-1227

TOLL FREE 1-800-332-0353

If you were hurt on the job and have any questions about workers compensation benefits, contact the **Ombudsman/Claims Advisory Unit** of the Division of Workers Compensation. The division has full-time personnel who specialize in aiding injured workers with claim information and problems. They can provide information about benefits an injured worker may be entitled to receive. They can help solve problems with benefits not being paid on time, medical treatment, unpaid medical bills, questions about how to figure settlement amounts, etc. Assistance in Spanish is available.

WHAT TO DO IF AN ACCIDENT OCCURS ON THE JOB

1. Tell your employer that you were hurt on the job.

2. Follow your employer's instructions for getting medical aid and follow the doctor's instructions.

3. Within 200 days of the date of accident or date of last payment of compensation for disability or date of last authorized medical care, tell your employer **in writing** that you expect workers compensation benefits for your injury. Your employer might know you were hurt and compensation may be paid, however, you could lose all rights to future compensation if you do not tell the employer **in writing**. This is called a **Written Claim for Workers Compensation, K-WC 15,** and is available from the division. A written claim may be served in person by taking it to the employer to complete, sign, date top half and return it to injured worker (injured worker completes bottom half), or by mailing it to the employer by certified mail, return receipt requested. The post office receipt for the certified letter is generally sufficient proof that you submitted a written claim.

AVERAGE WEEKLY WAGE: A worker's "average weekly wage" is calculated by adding together the **base wage**, the **average weekly overtime** and the **weekly value of fringe benefits** that have been discontinued.

WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they

are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas workers compensation law provides for additional benefits.

MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

RESPONSIBILITIES OF THE EMPLOYER

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company _____

Address _____

_____

Contact Person _____

Telephone (_____) _____

E-mail _____

KANSAS
DEPARTMENT OF LABOR
Division of Workers Compensation

Employee Notification Forms Available Online

Important Information for Employers Regarding Forms K-WC 27 and K-WC 270 (Spanish)

Kansas law requires employers to provide information to employees about what to do if they experience a work-related accident. Employers must provide Form K-WC 27 and/or K-WC 270, which advise workers about their rights and responsibilities if injured on the job. Both of these forms are available for employees online at www.dol.ks.gov.

The Legislature mandated under K.S.A. 44-5,102 (c): "The commissioner of insurance shall distribute a copy of such information to each insurance company authorized to transact workers compensation insurance in this state and each group-funded self-insurance plan. Each such insurance company and group-funded self-insurance plan shall reproduce or arrange for the reproduction and distribution of such information in sufficient quantities, and in both English and Spanish language versions, when requested, to continuously accommodate the needs of their respective insured employers and members in order to comply with this section and shall provide such information to such insured employers and members therefor."

The Insurance Commissioner sent certified letters to each insurance company licensed to sell workers compensation insurance in Kansas, as well as each group self-insurance pool. Each company returned a signed form stating the company had received the required forms and would provide the required form to each employer that they insure or that is a member of the approved "pool." The Director of the Division of Workers Compensation provides the same information to each of the approved self-insured employers. Effective December 1, 1993, every employer was under statutory requirement to provide a copy of the form K-WC 27 or K-WC 270 to injured employees.

K.S.A. 44-5,102(a) states: "Immediately on receiving notice of injury to or death of an employee, the employer shall mail or deliver to the employee or legal beneficiary" the form K-WC 27 or K-WC 270 provided by the Director of the Division of Workers Compensation. The Division has provided numerous educational opportunities through the annual Workers Compensation Seminars, Employer Institutes, other presentations, and individualized employer technical assistance visits since the requirement has been in effect. There has been an improvement in the utilization of the required informational. However, over half of the employers attending these training sessions were not using the required forms and informed the presenters that they had never received or seen these forms.

In an effort to assist employers in reaching compliance, the Division encourages employers to make copies of these forms, front and back (without changing the content). Employers should contact their insurance company if they haven't received this material.

Recurring questions from employers at the training sessions have been: "How do we prove that we gave the employee a copy of the form? Do we have to send it certified? Do we have to make them sign a piece of paper stating they received the form?"

Most employers keep a personnel log on employees. Generally, an entry in the log stating there was an alleged injury on this date and that a form K-WC 27 or K-WC 270 was given or sent to the employee should be adequate documentation of compliance with the requirement.

Questions regarding the form and its usage can be directed to the Ombudsman Section at 785-296-2996. A Spanish interpreter is available to explain the form if an employer/employee needs assistance in Spanish.

This notice must be posted and maintained by the employer in one or more conspicuous places.

★ NOTICE ★

Your employer is subject to the Kansas Workers Compensation law which provides compensation for job-related injuries.

1-800-332-0353

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

Notify your employer immediately. **Your claim may be denied if you fail to tell your employer within 10 DAYS of the injury**. For just cause you may have 75 days to tell the employer of your injury. Thereafter you **must** file a written claim within 200 days of the accident or last date benefits are paid. Submission of Employer's Report of Accident does not constitute a written claim.

MEDICAL BENEFITS

An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00.

WEEKLY BENEFITS

Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3% of his average weekly wage up to a maximum of 75% of the state's average weekly wage.

These benefits are subject to legislative changes and for the latest information on benefit levels, please contact the Division at the address and phone number below. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

Helpful Information – Ombudsman

Contact the **Ombudsman/Claims Advisory Section** at the Division of Workers Compensation immediately if you do not receive compensation in a timely manner. The Division has full-time personnel who specialize in aiding injured workers with claim problems. They can give information on what benefits an injured worker is entitled to receive. Such problems as benefits not being paid on time, unpaid medical bills, questions in regard to proper settlement amounts, etc., should be brought to the attention of the **Ombudsman/Claims Advisory Section**. Our toll free telephone number: **1-800-332-0353**.

WHERE TO GET HELP WITH YOUR CLAIM:

Current claims are being administered by _____

The claims office is located at _____ telephone ( ) _____

INFORMACIÓN SOBRE COMPENSACIÓN DE TRABAJADORES

La ley exige que cuando un trabajador llega a sufrir un accidente, una herida, o una enfermedad a causa de su empleo, el empleador debe proporcionarle al trabajador incapacitado tratamiento médico y otros beneficios sin ningún costo al trabajador. El trabajador incapacitado tiene derecho a recibir un sueldo reducido, mientras se restablece. La ley tambien protege los derechos del trabajador incapacitado en otras maneras, por ejemplo: se prohibe el desempleo de un trabajador solo por haber reclamado los beneficios de la compensación de trabajadores. Reporte cada accidente o lastimadura industrial inmediatamente al patrón, o al empleador.

Su reclamo puede ser negado si usted no notifica (avisa) a su empleador (patrón) dentro de 10 días del accidente o lastimadura. Por buena causa usted puede tener 75 días para avisarle a su empleador (patrón) de su accidente o lastimadura. De allí en adelante, usted debe entregar un aviso por escrito dentro de 200 días del accidente o último día que recibío tratamiento medico, o que recibío beneficios. Un reporte de accidente no constituta un aviso por escrito. Para mas información acerca de los beneficios o para recibir asistencia con un reclamo, llame al teléfono 1-800-332-0353 (gratis) o al 785-296-2996.

KANSAS
DEPARTMENT OF LABOR

Division of Workers Compensation
800 S.W. Jackson Street, Suite 600, Topeka, KS 66612-1227
Phone: 785-296-2996
Web site: www.dol.ks.gov • E-mail: wc@dol.ks.gov

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at 1-800-766-3777.

KANSAS
DEPARTMENT OF LABOR

EMPLOYER'S REPORT OF ACCIDENT

DIVISION OF WORKERS COMPENSATION
800 SW JACKSON STE 600
TOPEKA KS 66612-1227

Submit Original Report only

OSHA Case or File Number _____
There is a $250 penalty for repeated failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

DO NOT WRITE IN THIS SPACE

COUNTY

CAUSE

NATURE

SEVERITY

O – NO TIME LOST
1 – TIME LOST
2 – MEDICAL
3 – FATAL

SOURCE

MEMBER

DO NOT WRITE IN THIS SPACE

READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1. Federal Employer's Identification Number ..... Date of Hire .....
2. Name of Employer ..... Telephone Number ( ) .....
3. Mailing Address *Street* ..... *City* ..... *State* *Zip Code* .....
4. Location, if different from mailing address *Street* ..... *City* ..... *State* *Zip Code* .....
5. Nature of Business ..... NAICS or S.I.C. Code ..... Dept. or Division .....
6. Name of Employee *First* ..... *Middle* ..... *Last* ..... Age ..... Sex .....
7. Home Address *Street* ..... *City* ..... *State* *Zip Code* .....
8. Soc. Sec. # ..... Birth Date ..... Emp's Occupation ..... Home Ph. # ( ) .....
9. Date of Injury or Occupational Disease ..... Time of injury ..... ☐ A.M. ☐ P.M.
   Date Reported to Employer ..... Date Disability Began ..... Gross Average Weekly Wage $ .....
10. Place of Accident or last exposure *City* ..... *County* ..... *State* .....
11. Was accident or last exposure on employer's premises? ☐ YES ☐ NO
12. How did accident occur? .....
13. What was employee doing when injured? .....
14. Name substance or object that directly caused injury .....
15. Describe in detail nature and extent of injury, indicate part of body involved .....
16. Was worker admitted to hospital? ☐ YES ☐ NO Date ..... Treated by emergency room only? ☐ YES ☐ NO
    Hospital name & address .....
17. Name and address of attending physician or clinic .....
18. Has employee returned to regular duty? ☐ YES ☐ NO Light duty? ☐ YES ☐ NO Date .....
19. Is compensation now being paid? ☐ YES ☐ NO Date first/initial payment .....
20. Weekly compensation rate $ ..... Is further medical aid needed? ☐ YES ☐ NO ☐ UNKNOWN
21. Did employee die? ☐ YES ☐ NO If so, give date of death (File amended report within 28 days if death subsequently occurs.)
22. Name and address of dependents (death cases only) .....
23. Insurance Carrier and Third Party Administrator .....
    Address *Street* ..... *City* ..... *State* *Zip* *Phone*
    Policy Number Name of Agent
    Claim Number Name of Claim Representative
24. Date of Report Completed by Title

Questions or comments can be directed to the Kansas Division of Workers Compensation, Topeka, KS - Phone: 1-800-332-0353

K-WC 1101-A (Rev. 2-06)
221-8757 (12/11)

- SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY -

OSHA Case Information
(not to be filed with the Division of Workers Compensation)

25. **Case number from the Log** *(Transfer the case number from the Log after you record the case.)*

26. **Date of injury or illness**

27. **Time employee began work** ☐ A.M. ☐ P.M.

28. **Time of event** ☐ A.M. ☐ P.M. Check if time cannot be determined ☐

29. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. *Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."*

30. **What happened?** Tell us how the injury occurred. *Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was spraying with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."*

31. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected. Be more specific than "hurt," "pain," or "sore." *Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."*

32. **What object or substance directly harmed the employee?** *Examples: "concrete floor"; "chlorine"; "radial arm saw."* If this question does not apply to the incident, leave blank.

33. **If the employee died, when did death occur?** Date of death

General Instructions

Please answer every question on the accident report. Failure to provide all answers may cause the accident report to be returned to the employer. Returned accident reports would most likely cause delays in benefits being paid to the injured employees and could subject the employer to fines.

Submit the original report only. Reports must be typewritten, computer generated, or neatly printed in black ink. Please avoid faxing or sending copies of accident reports, as they are difficult for the Division to microfilm.

The employer should send this accident report to its insurance carrier, third party administrator or pool association as indicated in the employer's insurance contract. The employer is responsible for submitting or causing the original report to be sent to the Division's office within 28 days of the date of the employer's receipt of knowledge of the accident.

Submission of this Employer's Report of Accident does not constitute a written claim.

Definition of an Incapacitating Injury

The Workers Compensation Act sets forth a strict time frame for filing of accident reports with the Division. The controlling statute is K.S.A. 44-557(a), which reads as follows:

> (a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

Accident reports are not required for every work related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the Division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. There are penalties, however, for failing to file a report when one was required. Those penalties are fines and limitations on the defenses the employer may assert should a claim be filed.

Instructions for Specific Items

Item 14: Name the object or substance which directly injured the employee. Examples: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling; etc.

Item 15: Please be as specific as possible indicating all that is known about the injury. Name part of body injured.